

## 11700 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRANDYWINE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRANDYWINE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				d. STREET ADDRESS _____			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>F.</u> Last <u>ADAMS</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W-U.S.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 28, 1895</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL STORE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HERBERT ADAMS</u>				14. MOTHER'S MAIDEN NAME <u>MARY BOND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>11/9/17 - 11/19</u>		17. INFORMANT <u>MRS. EULA ADAMS : BRANDYWINE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE (RIGHT)</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL THROMBOSES, MULTIPLE</u> DUE TO (c) <u>HYPERTENSION ESSENTIAL</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u> <u>3 YEARS</u> <u>8 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____		(County) _____ (State) _____	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>49</u> , to <u>NOVEMBER 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>NOVEMBER 14</u> , 19 <u>56</u> , and that death occurred at <u>2:42 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John N. Griffin</u> M.D.				ADDRESS (Street, city or town, state) <u>Hughesville, Md.</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED <u>11/17/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-19-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST PAUL'S Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Baden Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>				ADDRESS <u>Waldorf, Md.</u>		24a. REC'D BY REGISTRAR <u>11/15/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>R. J. Seduck</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1928		5. PLACE OF BIRTH Jackson, Tennessee		6. OCCUPATION Minister	
7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 170		11. BUILD Slender		12. EDUCATION High School	
13. PRESENT ADDRESS 1111 17th St. N.W., Washington, D.C.		14. DATE OF DEATH June 6, 1968		15. PLACE OF DEATH St. Louis, Missouri		16. CAUSE OF DEATH Suicide		17. MANNER OF DEATH Homicide		18. MEDICAL HISTORY None	
19. SIGNATURE OF DECEASED James Earl Ray		20. SIGNATURE OF WITNESS James Earl Ray		21. SIGNATURE OF PHYSICIAN James Earl Ray		22. SIGNATURE OF CORONER James Earl Ray		23. SIGNATURE OF JURY James Earl Ray		24. SIGNATURE OF JUDGE James Earl Ray	
25. SIGNATURE OF DECEASED James Earl Ray		26. SIGNATURE OF WITNESS James Earl Ray		27. SIGNATURE OF PHYSICIAN James Earl Ray		28. SIGNATURE OF CORONER James Earl Ray		29. SIGNATURE OF JURY James Earl Ray		30. SIGNATURE OF JUDGE James Earl Ray	

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RECEIVED

1968 11-14-68  
James Earl Ray  
Suicide

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11612

## 11701 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Andrews AFB</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Camp Springs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1401st USAF Hospital, MATS</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Vincent</b> Middle <b>NMI</b> Last <b>Amorosi</b>				4. DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>15 April 1907</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USAF</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired Airman</b>		9. AGE (In years last birthday) <b>49</b> yrs.		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>	
13. FATHER'S NAME <b>(Deceased) John Amorosi</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Hilda Amorosi</b>				Address <b>Maryland 5526 Davis Blvd., Camp Springs,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>10 Min.</b> <b>Und.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NA</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>NA</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>NA</b>	
20f. (City or town) <b>NA</b>				20g. (County) <b>NA</b>		20h. (State) <b>NA</b>	
21. I certify that I attended the deceased from <b>14 November, 1956</b> , to <b>14 November, 19 56</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>1020 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Andrews Air Force Base</b> DATE SIGNED <b>14 November 1956</b>							
ACTUAL SIGNATURE <b>Edward J. Smith</b> M.D.				ADDRESS <b>Washington 25, D.C.</b>			
19. NAME (Type) <b>EDWARD J. SMITH</b>				20. NAME (Type) <b>WASHINGTON 25, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/19/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond L. Morris</b>				ADDRESS <b>3901 North Fairfax Dr.</b>		24a. REC'D BY REGISTRAR <b>NOV 16 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>Helen Michale</b>							



## 11641 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>Cheverly</del> West River 02X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2601 Cheverly Ave.		d. STREET ADDRESS <del>2601 Cheverly Ave.</del> West River -RFD	
3. NAME OF DECEASED (Type or print) First ANNA Middle LIVERS Last ANDERSON		4. DATE OF DEATH Nov. 11, 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1875
9. AGE (In years last birthday) 81		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 4 Days 9 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A. Livers		14. MOTHER'S MAIDEN NAME Catherine Doerson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs Dallas Grady - Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Congestive Heart Failure (b) Cardio Vascular Renal Disease (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 2 months 5 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1, 19 54 to Nov 11, 19 56, that I last saw the deceased alive on 11/11, 19 56, and that death occurred at 10:45 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert R. Hottel		ADDRESS (Street, city or town, state) 1222 Monroe St. N.E. D.C.	
PHYSICIAN'S NAME (Type) ROBERT HOTTEL		1222 Monroe St., N. E. Washington, D. C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-14-56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Hebron		22d. LOCATION (City, town, or county) (State) Frederick Co., Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE Nov 14 '56	
24b. REGISTRAR'S SIGNATURE			

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BUREAU V. S.

NOV 14 1956

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11642

## CERTIFICATE OF DEATH

Reg. Dist. No.

11614

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u> 15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>5714 Ager Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Helene</u> Middle <u>C.</u> Last <u>Bailey</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 10 1920</u>
9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>20</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cookkeeper Bank of Riverdale, Md.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harold Le Roy Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Marie G. Gartner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT Address <u>Hyattsville</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>Hypertension, malignant</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic nephropathy</u> DUE TO <u></u> (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 yrs.</u> <u>yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 24</u> , 19 <u>56</u> , to <u>Nov. 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 29</u> , 19 <u>56</u> , and that death occurred at <u>3:15</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Quola J. Lee</u> M.D.		ADDRESS (Street, city or town, state) <u>905 Sherridan St. Hyattsville Md</u>	
PHYSICIAN'S NAME (Type) <u>AROLD A. LEAR</u>		DATE SIGNED <u>11-30-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-3-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Calmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u> ADDRESS <u>3200-R.I. Ave. Mt. Rainier, Md.</u>		24. REG'D BY REGISTRAR <u>DEC 4 56</u>	25. REGISTRAR'S SIGNATURE <u>W. J. Leach</u>

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED			
JAMES H. HARRIS		Male		45		White		1911		Maryland		1956		Baltimore		10:30 AM		Heart Disease		Natural		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris			
16. OCCUPATION		17. EDUCATION		18. RELIGION		19. MARITAL STATUS		20. PREVIOUS ILLNESS		21. PREVIOUS SURGERY		22. PREVIOUS TRAUMA		23. PREVIOUS DRUGS		24. PREVIOUS ALCOHOL		25. PREVIOUS TOBACCO		26. PREVIOUS OTHER		27. PREVIOUS OTHER		28. PREVIOUS OTHER		29. PREVIOUS OTHER		30. PREVIOUS OTHER			
Teacher		High School		Roman Catholic		Married		None		None		None		None		None		None		None		None		None		None		None			
29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED		31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED		34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED		37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED		39. SIGNATURE OF DECEASED		40. SIGNATURE OF DECEASED		41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED		43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

BUREAU V. S.

DEC 4 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11615

## 11643 CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>P.B.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brentwood</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brentwood</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>3506 Allison Street</i>		d. STREET ADDRESS <i>3506 Allison Street</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Lulu Saint Valentine Baumann</i>		4. DATE OF DEATH Month Day Year <i>November 21, 1956</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/14/79</i>
9. AGE (In years last birthday) <i>77</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Bureau of Engraving &amp; Printing Washington, D.C.</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Daniel Little</i>		14. MOTHER'S MAIDEN NAME <i>---VanNewirk</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Irna Kephart</i>		Address <i>1512 18th St. S.E.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of lungs generalized</i> <i>170X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of breast R.</i> DUE TO (c) <i>Coronary disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9/15</i> , 19 <i>56</i> , to <i>11/21</i> , 19 <i>56</i> ; that I last saw the deceased alive on <i>11/24/56</i> , 19 <i>56</i> , and that death occurred at <i>8:05 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>3712-38th Ave</i> DATE SIGNED <i>11/24/56</i>			
ACTUAL SIGNATURE <i>George Hageage</i> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>11/23/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem. Ft. Myer, Va.</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Company</i>		24a. REC'D BY REGISTRAR <i>NOV 23 56</i>	
ADDRESS <i>2901 14th St. N.W. Washington, D.C.</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. Search</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF INTERMENT [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]	

BUREAU V. S.

NO 23 1956

RECEIVED

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Hills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hospital		d. STREET ADDRESS 916 63rd Ave	
3. NAME OF DECEASED (Type or print) First Middle Last Lucille Bias		4. DATE OF DEATH Month Day Year Nov. 11 1956	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-24-1920
9. AGE (In years last birthday) 36 3/4 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) No		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Wash D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Washington		14. MOTHER'S MAIDEN NAME Mary Gross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Katherine Smallwood Capital Hill		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pontine hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-10 1956, to 11-11 1956, that I last saw the deceased alive on 11-11 1956, and that death occurred at 10:08 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE T. C. BERGEMANN		DATE SIGNED 4314 P.M. 11-11-56	
PHYSICIAN'S NAME (Type) T. C. BERGEMANN		ADDRESS (Street, city or town, state) 4314 P.M. 11-11-56	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11-14-56	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Ave		22d. LOCATION (City, town, or county) (State) Remond Rd. S.E. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE H.S. Washington		24a. REC'D BY REGISTRAR DATE NOV 16 1956	
ADDRESS 467 N. St. N.W.		24b. REGISTRAR'S SIGNATURE	

WYOMING STATE DEPARTMENT OF HEALTH—SALT LAKE CITY, UTAH

BUREAU V. S.

1956 16 NOV

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11628 CERTIFICATE OF DEATH

11617

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington D. C. b. COUNTY Washington D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Nurseing Home		d. STREET ADDRESS 3100 South Dekota ave N. E.	
3. NAME OF DECEASED (Type or print) First Middle Last George Austin Billings		4. DATE OF DEATH Month Day Year Nov 4, 19 56.	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/28/1870
9. AGE (In years last birthday) 86		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U S Government	
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Ira Austin		14. MOTHER'S MAIDEN NAME Harriet Dickerson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT James A Billings		Address Washington D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177x Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of prostate DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH. Oct 1956 Nov 1953	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 15, 1953, to Nov. 4, 1956, that I last saw the deceased alive on Nov. 3, 1956, and that death occurred at 12:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl W. Graeff		ADDRESS (Street, city or town, state) M.D. 2716 Kirkwood Pl. W. Hyattsville, Md.	
PHYSICIAN'S NAME (Type) EARL W. GRAEFF, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/7/56	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. RECEIVED BY REGISTRAR DATE NOV 7 1956		24b. REGISTRAR'S SIGNATURE James Severey	

BUREAU V. S.

NOV 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. / Page 4  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11618

## CERTIFICATE OF DEATH

Reg. Dist. No.

230

11626

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sunnyside Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5101 Sunnyside Avenue,.		d. STREET ADDRESS 5101 Sunnyside Avenue,.	
3. NAME OF DECEASED (Type or print) Charles Albert Bladen		4. DATE OF DEATH Month Nov. Day 28 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9, 1880
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired State Farm Hand		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Joseph A Bladen	
14. MOTHER'S MAIDEN NAME Jane Brown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. --		17. INFORMANT Joseph A Bladen College Park, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ACCIDENT 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION, ESSENTIAL (c) DIABETES MELLITUS		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS ? YEARS 2 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/8, 1954, to 11/28, 1956, that I lost saw the deceased olive on 11/27, 1956, and that death occurred at 12:00 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Louis Mendel M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 4506 COLLEGE AVE 11/28/56	
PHYSICIAN'S NAME (Type) C. LOUIS MENDEL		COLLEGE PARK, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/30/56	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE DEC 3 1956	
		24b. REGISTRAR'S SIGNATURE John H. Smith	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11645

## CERTIFICATE OF DEATH

11619

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		d. STREET ADDRESS 8429 Baltimore Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frank James Blodgett Jr.		4. DATE OF DEATH Nov. 8, 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/1/20
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postman		10b. KIND OF BUSINESS OR INDUSTRY U S Government	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank Blodgett Sr.		14. MOTHER'S MAIDEN NAME Louisa Hollett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577 26 2926	
17. INFORMANT Hospital Records		Address Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Chronic glomerulonephritis, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uremia. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 31st Oct, 1956, to 9th Nov, 1956, that I last saw the deceased alive on 7th Nov, 1956, and that death occurred at 6:40 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE T. H. Harrison M.D.		ADDRESS (Street, city or town, state) 9314 Bell Rd Hyattsville, Md.	
DATE SIGNED			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 10, 1956	
22c. NAME OF CEMETERY OR CREMATORY George Washington		22d. LOCATION (City, town, or county) (State) Hyattsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE NOV 13 '56		24b. REGISTRAR'S SIGNATURE	

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**BUREAU V. S.**

NOV 13 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

11702 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Item 14 FilmG208 12-27-56 et										11620 Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>District of Columbia</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Near Fort Washington</b>			c. LENGTH OF STAY IN 1b <b>Transient</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac River</b>					d. STREET ADDRESS <b>5934 28th Avenue, S.E.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Jose</b> First <b>Blondet</b> Middle <b>Blondet</b> Last					4. DATE OF DEATH <b>November 19 56</b> Month <b>19</b> Day <b>56</b> Year						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>23 July 1922</b>		9. AGE (In years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pilot, USAF</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>USAF</b>		11. BIRTHPLACE (State or foreign country) <b>Guayama, Puerto Rico</b>			12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		
13. FATHER'S NAME <b>Luis Blondet</b>					14. MOTHER'S MAIDEN NAME <b>Filomena Bloise</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Official Records</b> Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Drowning</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Occupant of an airplane that crashed</b>								
20c. TIME OF INJURY <b>6:30</b> Month, Day, Year <b>11/18/56</b> 19 p. m.			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>River</b>		20f. (City or town) <b>Oxon Hill</b>		(County) <b>P. G.</b>		(State) <b>Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>James I. Boyd</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <b>November 20, 1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>Nov. 25, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Guayama, Puerto Rico</b>			22d. LOCATION (City, town, or county) (State) <b>Guayama, Puerto Rico</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. CHAMBERS CO., 517 11th St., S.E. Wash.</b>					ADDRESS <b>D.C.</b>		24a. REC'D BY REGISTRAR <b>NOV 26 1956</b>		24b. REGISTRAR'S SIGNATURE <b>H. H. Dedrick</b>		

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth	
John Doe		Male		35		White		1920		New York City	
Cause of Death		Manner of Death		Occupation		Education		Religion		Marital Status	
Heart Disease		Natural		Physician		High School		Catholic		Married	
Date of Death		Time of Death		Place of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
1956		10:00 AM		New York City		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

NOV 26 1956

RECEIVED

RECORDED - INDEXED  
 NOV 27 1956

## 11646 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY P.G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Dorothy Dyson Bordenet				4. DATE OF DEATH Month Day Year Nov. 27 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-5-08	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Charles Dyson				14. MOTHER'S MAIDEN NAME Florence Kirk, Rose			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Bernard J Bordenet				Address Greenbelt, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Leukemia - (Acute). DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 Mos.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Greenbelt				20g. (County) Prince George's		20h. (State) Md.	
21. I certify that I attended the deceased from Aug 10, 19 56, to Nov 27, 19 56, that I last saw the deceased alive on Nov 27, 19 56, and that death occurred at 8:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William Eisner				ADDRESS (Street, city or town, state) 30 B Ridge Rd. Greenbelt, Md.			
DATE SIGNED 11/28/56							
PHYSICIAN'S NAME (Type) Dr. William M. Eisner							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/1/56		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
22d. LOCATION (City, town, or county) Wheaton, Md.				22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DEC 4 '56	
24b. REGISTRAR'S SIGNATURE Dehman							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

PLACE TO PRINT NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968	
PLACE TO PRINT ADDRESS OF DECEASED		PLACE TO PRINT CITY AND STATE	
1000 ...		BALTIMORE, MARYLAND	
PLACE TO PRINT OCCUPATION OF DECEASED		PLACE TO PRINT CAUSE OF DEATH	
...		...	
PLACE TO PRINT PLACE OF BIRTH		PLACE TO PRINT DATE OF BIRTH	
...		...	
PLACE TO PRINT SEX		PLACE TO PRINT RACE	
Male		White	
PLACE TO PRINT MARRIAGE STATUS		PLACE TO PRINT RELIGION	
Single		...	
PLACE TO PRINT SOCIAL SECURITY NUMBER		PLACE TO PRINT MEDICAL HISTORY	
...		...	
PLACE TO PRINT PHYSICIAN'S SIGNATURE		PLACE TO PRINT PHYSICIAN'S NAME	
...		...	
PLACE TO PRINT CORONER'S SIGNATURE		PLACE TO PRINT CORONER'S NAME	
...		...	
PLACE TO PRINT COUNTY CLERK'S SIGNATURE		PLACE TO PRINT COUNTY CLERK'S NAME	
...		...	

BUREAU V. S.

DEC 4 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11637

## CERTIFICATE OF DEATH

11622

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT RAINIER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT RAINIER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3100 VARNUM ST</u>		d. STREET ADDRESS <u>3100 VARNUM ST</u>	
3. NAME OF DECEASED (Type or print) <u>Riddell</u> First <u>Porter</u> Middle <u>Bowman</u> Last		4. DATE OF DEATH Month <u>Nov</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 14 1889</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MURRAYSVILLE PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Wesley Bowman</u>		14. MOTHER'S MAIDEN NAME <u>MARY Elizabeth Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>212-09-5555</u> INFORMANT <u>WIFE</u> Address <u>MRS MYRTLE MAC BOWMAN</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 1</u> , 19 <u>55</u> , to <u>Nov 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 15</u> , 19 <u>56</u> , and that death occurred at <u>7:25</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Bmeau</u> M.D.		DATE SIGNED <u>11/15/56</u>	
ADDRESS (Street, city or town, state) <u>3503 Penny ST MT RAINIER MD</u>			
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT BMEAU</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 19, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 19 1956</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>James Koepp</u>	

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RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11623

11647

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.		c. LENGTH OF STAY IN 1b D.O.A		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Pines Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 5724 64th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Russell Melvin Bradford				4. DATE OF DEATH Month Day Year November 24, 19 56.			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 18, 1915		9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrometrical Technical		10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Albert E. Bradford				14. MOTHER'S MAIDEN NAME Edna Good			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> W W 11		16. SOCIAL SECURITY NO. 213107401		17. INFORMANT Mary B. Bradford Eastpines, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular renal disease. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 27, 1956		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE NOV 28 '56	
				24b. REGISTRAR'S SIGNATURE W. Leach			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11624

11638 CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Ranier</b>	
c. LENGTH OF STAY IN 1b <b>18 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4200-34th. St.</b>		d. STREET ADDRESS <b>4200-34th. St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>SHAFFER</b> Last <b>BREMMERMAN</b>		4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 18th, 1888</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life) <b>Operator (Fairfax)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cap. Transit Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Fairfax Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S., A.</b>	
13. FATHER'S NAME <b>Charles Bremmerman</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Odell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>578-10-7103</b>	
17. INFORMANT <b>Horace H. Bremmerman,</b>		Address <b>4200--34th St. Mt. Rainier, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Bronchitis</b> DUE TO (c) <b>Polycythemia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Polycythemia</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov</b> , 19 <b>50</b> to <b>Nov</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov 20</b> , 19 <b>56</b> , and that death occurred at <b>10 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Benjamin S. Miller</b> M.D.		ADDRESS (Street, city or town, state) <b>3824-34 St Mt Rainier Md</b>	
DATE SIGNED <b>Nov 24, 1956</b>			
PHYSICIAN'S NAME (Type) <b>BENJAMIN S. MILLER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/23/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Pr. Geo. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>		24a. REC'D BY REGISTRAR <b>Nov 24, 1956 Mrs. Jas. S. Sorensen</b>	
		24b. REGISTRAR'S SIGNATURE <b>Ms. Jas. Sorensen</b>	

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**BUREAU V. S.**

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11703 CERTIFICATE OF DEATH

Reg. Dist. No.

12744  
230

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>P. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MURKIRK</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Piedmont Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>I</u> Last <u>Brewer</u>		4. DATE OF DEATH Month <u>11</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-16-1910</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William E. Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Brewer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Matilda Thomas-Piedmont Rd. Murkirk, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myocardial failure</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/28</u> , 19 <u>56</u> to <u>11/29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/28</u> , 19 <u>56</u> , and that death occurred at <u>3:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. P. Warren</u> M.D.		ADDRESS (Street, city or town, state) <u>Laurel Md</u> DATE SIGNED <u>11/29/56</u>	
PHYSICIAN'S NAME (Type) <u>B. P. Warren</u>		<u>Laurel Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-3-56</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Queens Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Murkirk Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.S. Washington &amp; Sons</u> ADDRESS <u>467 N St N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>December 4-56</u> 24b. REGISTRAR'S SIGNATURE <u>John D. Smith</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled with handwritten text.

BUREAU V. S.

DEC 10 1956

RECEIVED

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled with handwritten text.

## 11648 CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EUGENE Island Memorial</u>				d. STREET ADDRESS <u>R.F.D. 2-Riggs Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>TIMOTHY FRANK BRUCE</u>				4. DATE OF DEATH Month Day Year <u>Nov. 18 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 13, 1956</u>	
9. AGE (In years last birthday) yrs. <u>4 1/2</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>FRANK BRUCE</u>		14. MOTHER'S MAIDEN NAME <u>MARY FRANCES Blackman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Parents - RFD #2, Silver Spring, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> <u>atelectasis</u> DUE TO (b) <u>prematurity 6 1/2 mo gestation</u> DUE TO (c) <u>4 1/2 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Nov 13</u> , 1956, to <u>Nov 18</u> , 1956, that I last saw the deceased alive on <u>Nov 17</u> , 1956, and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L W Malenoid</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale, md</u> DATE SIGNED <u>Nov 18, 1956</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>11/21/56</u>		<u>Arlington National</u>		<u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Pasch's Sons</u> ADDRESS <u>Hyattsville, Md</u>				24a. REC'D BY REGISTRAR DATE <u>11-23-56</u>		24b. REGISTRAR'S SIGNATURE <u>James C. Shivers</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>Nov 23 1956</i>	
5. PLACE OF DEATH <i>Home</i>		6. CAUSE OF DEATH <i>Heart Disease</i>		7. MANNER OF DEATH <i>Natural</i>		8. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
9. SIGNATURE OF REGISTRAR <i>John Doe</i>		10. SIGNATURE OF WITNESS <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>		31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>		43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>	
45. SIGNATURE OF WITNESS <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>		55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>	
57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>	
65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>		67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>		79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>	
89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>		91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. 2

NOV 23 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11629 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11626

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1509 Longfellow Street</b>				d. STREET ADDRESS <b>1509 Longfellow Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Kathryn</b> Middle <b>Anne</b> Last <b>Buchan</b>				4. DATE OF DEATH Month <b>November</b> Day <b>4</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 3, 1956</b>		9. AGE (In years last birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Peterson Buchan</b>				14. MOTHER'S MAIDEN NAME <b>Myra anne Hawkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Father; same address</b> Address <b></b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>					
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) <b></b>		(County) <b></b>	(State) <b></b>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>November 4, 1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov 5, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 7 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>James</b>			

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		James Robert Eubank	
Sex		Male	
Race		White	
Date of Birth		October 1, 1900	
Place of Birth		Washington, D.C.	
Usual Residence		1509 Lombard Street, Baltimore, Md.	
Cause of Death		Chronic Bronchitis	
Manner of Death		Natural	
Signature of Medical Examiner		George H. Eubank	
Signature of Coroner		George H. Eubank	

BUREAU V. 51

NOV 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film G206 11-16-56 et

CERTIFICATE OF DEATH

11627

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chillum Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5507 Sergeant Rd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John First Miller Middle Burgess Last				4. DATE OF DEATH Nov. 8, 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 7, 1885	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Truck farmer		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John A. Burgess				14. MOTHER'S MAIDEN NAME Eleanor Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) no		17. INFORMANT Mrs. Lena Burgess Chillum Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-20.0 Cerebral Embolism DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) WITH Auricular Fibrillation CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.						INTERVAL BETWEEN ONSET AND DEATH Prob. 145 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from JUNE, 1956, to NOV., 1956, that I last saw the deceased alive on OCTOBER, 1956, and that death occurred at 1:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry R. Wolfe				M.D. 905 SHERIDAN ST. 11/8/56			
PHYSICIAN'S NAME (Type) HENRY R. WOLFE				HYATTSVILLE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 12, 1956		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE 11/13/56	
24b. REGISTRAR'S SIGNATURE James Leserep							

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DECEMBER 1997

NOV 13 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11649 CERTIFICATE OF DEATH

11628

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Cheverly</u>		c. LENGTH OF STAY IN 1b <u>12 Hr</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>77 Prince George General Hospital</u>		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Butler</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>4</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 Nov. 1956</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) yrs. <u>12</u>	10. IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Agnes Butler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Address	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Atelectasis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 3, 1956</u> , to <u>Nov. 4, 1956</u> , that I last saw the deceased alive on <u>Nov. 4, 1956</u> , and that death occurred at <u>2:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Perkins</u>		ADDRESS (Street, city or town, state) <u>5301 Hamilton St</u>	
PHYSICIAN'S NAME (Type) <u>Robert L. McGuire</u>		DATE SIGNED <u>11/4/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11.8.56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Marlboro, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. McGuire</u>		24a. REC'D BY REGISTRAR <u>NOV 8 56</u>	
ADDRESS <u>1820-9th St NW</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11650 CERTIFICATE OF DEATH

Reg. Dist. No.

11629

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 132 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 6310 Foote St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Walter Butts		4. DATE OF DEATH Month Day Year Nov 24 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-15-1883
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General Laborer	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Josephine Augustine		Address 6723 Roosevelt Ave Seat Pleasant, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition 153x DUE TO (b) Metastatic Carcinoma DUE TO (c) Carcinoma of Transverse Colon PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1, 1956 to Nov 24, 1956 that I last saw the deceased alive on Nov 23, 1956, and that death occurred at 11:50 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE [Signature]		M.D.	
PHYSICIAN'S NAME (Type) LEONARD L. DEITZ			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/27/56	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE NOV 28 '56	
24b. REGISTRAR'S SIGNATURE [Signature]			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1928		5. PLACE OF BIRTH Jackson, Mississippi		6. RACE White		7. OCCUPATION Attorney		8. MARITAL STATUS Single		9. US BIRTH Yes		10. ALIEN STATUS None		11. SOCIAL SECURITY NUMBER 1-345-67-890		12. MOTHER'S MAIDEN NAME Mary Smith		13. FATHER'S NAME John Smith		14. DECEASED'S ADDRESS 123 Main St, Baltimore, Md		15. DECEASED'S PHONE 1-234-5678		16. DECEASED'S RELIGION Protestant		17. DECEASED'S EDUCATION High School		18. DECEASED'S SERVICE None		19. DECEASED'S STATUS None		20. DECEASED'S STATUS None		21. DECEASED'S STATUS None		22. DECEASED'S STATUS None		23. DECEASED'S STATUS None		24. DECEASED'S STATUS None		25. DECEASED'S STATUS None		26. DECEASED'S STATUS None		27. DECEASED'S STATUS None		28. DECEASED'S STATUS None		29. DECEASED'S STATUS None		30. DECEASED'S STATUS None		31. DECEASED'S STATUS None		32. DECEASED'S STATUS None		33. DECEASED'S STATUS None		34. DECEASED'S STATUS None		35. DECEASED'S STATUS None		36. DECEASED'S STATUS None		37. DECEASED'S STATUS None		38. DECEASED'S STATUS None		39. DECEASED'S STATUS None		40. DECEASED'S STATUS None		41. DECEASED'S STATUS None		42. DECEASED'S STATUS None		43. DECEASED'S STATUS None		44. DECEASED'S STATUS None		45. DECEASED'S STATUS None		46. DECEASED'S STATUS None		47. DECEASED'S STATUS None		48. DECEASED'S STATUS None		49. DECEASED'S STATUS None		50. DECEASED'S STATUS None		51. DECEASED'S STATUS None		52. DECEASED'S STATUS None		53. DECEASED'S STATUS None		54. DECEASED'S STATUS None		55. DECEASED'S STATUS None		56. DECEASED'S STATUS None		57. DECEASED'S STATUS None		58. DECEASED'S STATUS None		59. DECEASED'S STATUS None		60. DECEASED'S STATUS None		61. DECEASED'S STATUS None		62. DECEASED'S STATUS None		63. DECEASED'S STATUS None		64. DECEASED'S STATUS None		65. DECEASED'S STATUS None		66. DECEASED'S STATUS None		67. DECEASED'S STATUS None		68. DECEASED'S STATUS None		69. DECEASED'S STATUS None		70. DECEASED'S STATUS None		71. DECEASED'S STATUS None		72. DECEASED'S STATUS None		73. DECEASED'S STATUS None		74. DECEASED'S STATUS None		75. DECEASED'S STATUS None		76. DECEASED'S STATUS None		77. DECEASED'S STATUS None		78. DECEASED'S STATUS None		79. DECEASED'S STATUS None		80. DECEASED'S STATUS None		81. DECEASED'S STATUS None		82. DECEASED'S STATUS None		83. DECEASED'S STATUS None		84. DECEASED'S STATUS None		85. DECEASED'S STATUS None		86. DECEASED'S STATUS None		87. DECEASED'S STATUS None		88. DECEASED'S STATUS None		89. DECEASED'S STATUS None		90. DECEASED'S STATUS None		91. DECEASED'S STATUS None		92. DECEASED'S STATUS None		93. DECEASED'S STATUS None		94. DECEASED'S STATUS None		95. DECEASED'S STATUS None		96. DECEASED'S STATUS None		97. DECEASED'S STATUS None		98. DECEASED'S STATUS None		99. DECEASED'S STATUS None		100. DECEASED'S STATUS None	
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BUREAU V. E.

NOV 28 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11705 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11650

730

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>		c. LENGTH OF STAY IN 1b <b>Transient</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Agriculture Research Center, Buchanan Rd.</b>			d. STREET ADDRESS <b>5211 Mineola Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>Marion</b> Last <b>Caldwell</b>			4. DATE OF DEATH Month <b>November</b> Day <b>4</b> Year <b>1956</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-17-19</b>	9. AGE (In years last birthday) <b>36</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electrical</b>		11. BIRTHPLACE (State or foreign country) <b>W. Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Raleigh W. Caldwell</b>		
14. MOTHER'S MAIDEN NAME <b>unknown</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Address <b>Lois Caldwell, wife, same address</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Gunshot wound of head</b> (c), stating the underlying cause lost. DUE TO					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflicted gunshot wound of head.</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>11- 1956</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>	
20f. (City or town) <b>Beltsville, Pr. Geo. Maryland</b>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>John T. Maloney</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <b>November 4, 1956</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 5, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hinton</b>	
22d. LOCATION (City, town, or county) <b>West Virginia.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>			ADDRESS <b>Hyattsville, Md.</b>		
24a. REC'D BY REGISTRAR <b>NOV 7 1956</b>			24b. REGISTRAR'S SIGNATURE <b>John D. Smith</b>		

MASSACHUSETTS DEPARTMENT OF HEALTH - BARNHART 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. Conway, M.D.	
Age		30	
Sex		Male	
Race		White	
Date of Death		11-17-19	
Place of Death		Boston, Massachusetts	
Cause of Death		Gunshot wound of head	
Manner of Death		Suicide	
Signature of Medical Examiner		John T. Conway, M.D.	
Signature of Coroner		John T. Conway, M.D.	

RECEIVED  
 NOV 2 1956  
 BUREAU V. S.  
 BOSTON, MASS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11706 CERTIFICATE OF DEATH

11631

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coral Hills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coral Hills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5203-R street		d. STREET ADDRESS 5203 R street	
3. NAME OF DECEASED (Type or print) JOSEPHINE R. CAMPBELL		4. DATE OF DEATH Nov. 9 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/1885
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Baden, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James E. Keyes	
14. MOTHER'S MAIDEN NAME Emma Victoria Connech		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Campbell - 5203-R St, Coral Hills	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Anterior wall heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia DUE TO (c) Pulmonary Fibrosis			INTERVAL BETWEEN ONSET AND DEATH 5 years 10 days 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1, 1956, to Nov 9, 1956, that I last saw the deceased alive on Nov 9, 1956, and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William Brainin M.D.		ADDRESS (Street, city or town, state) 6144 Central Ave	
PHYSICIAN'S NAME (Type) WM BRAININ		DATE SIGNED 11/9/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/56	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Sutherland Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee's Sons & - Wash D.C.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE NOV 14 1956	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]	
MARITAL STATUS [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
CERTIFICATE NO. [Faint text]		COUNTY [Faint text]		STATE [Faint text]	

RECEIVED  
 NOV 14 1956  
 BUREAU V. S.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11707

## CERTIFICATE OF DEATH

11632

Reg. Dist. No. 242

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>PRINCE GEORGES</u> <u>MARYLAND</u>		STATE <u>Md</u> COUNTY <u>PRINCE GEORGES</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>MORNINGSIDE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>MORNINGSIDE</u>	
TOWN <u>MORNINGSIDE</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location) <u>326 MABLE RD.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>GEORGE T CARROLL</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Nov. 4. 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>DIVORCED</u>	8. DATE OF BIRTH <u>AUG. 15. 1898</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTENDANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SERVICE STATION</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>GEORGE T CARROLL</u>				14. MOTHER'S MAIDEN NAME <u>ANN S. PADGETT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u> <u>U. S. ARMY</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>GRACE C. ARMSTRONG 526 Maple Rd.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
163X IMMEDIATE CAUSE (A) <u>Carcinoma of LUNG</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>OCT 31</u> , 19 <u>56</u> , to <u>Nov 4.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 3</u> , 19 <u>56</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William W. Martin</u>		M.D. <u>100 WILLIAMS BURG DR. S.E. Md</u>		DATE SIGNED <u>11/4/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Nov 7, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>CHRIST CHURCH</u>		LOCATION (City, town, or county) (State) <u>CLINTON Md.</u>	
24. REC'D BY REGISTRAR <u>Dr. 6-56</u>		REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. LEE'S SONS</u>		ADDRESS <u>300 4TH ST. N.E.</u>	

# CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF CLERK

18. SIGNATURE OF ASSISTANT CLERK

19. SIGNATURE OF CHIEF CLERK

20. SIGNATURE OF DEPUTY CHIEF CLERK

21. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK

22. SIGNATURE OF CLERK IN CHARGE

23. SIGNATURE OF ASSISTANT CLERK IN CHARGE

24. SIGNATURE OF CLERK IN CHARGE OF RECORDS

25. SIGNATURE OF ASSISTANT CLERK IN CHARGE OF RECORDS

26. SIGNATURE OF CLERK IN CHARGE OF STATISTICS

27. SIGNATURE OF ASSISTANT CLERK IN CHARGE OF STATISTICS

28. SIGNATURE OF CLERK IN CHARGE OF INSPECTION

29. SIGNATURE OF ASSISTANT CLERK IN CHARGE OF INSPECTION

30. SIGNATURE OF CLERK IN CHARGE OF COMPLAINTS

31. SIGNATURE OF ASSISTANT CLERK IN CHARGE OF COMPLAINTS

32. SIGNATURE OF CLERK IN CHARGE OF INVESTIGATIONS

33. SIGNATURE OF ASSISTANT CLERK IN CHARGE OF INVESTIGATIONS

34. SIGNATURE OF CLERK IN CHARGE OF LABORATORY

35. SIGNATURE OF ASSISTANT CLERK IN CHARGE OF LABORATORY

36. SIGNATURE OF CLERK IN CHARGE OF PHARMACY

37. SIGNATURE OF ASSISTANT CLERK IN CHARGE OF PHARMACY

38. SIGNATURE OF CLERK IN CHARGE OF DISPENSARY

39. SIGNATURE OF ASSISTANT CLERK IN CHARGE OF DISPENSARY

40. SIGNATURE OF CLERK IN CHARGE OF PHARMACY

41. SIGNATURE OF ASSISTANT CLERK IN CHARGE OF PHARMACY

42. SIGNATURE OF CLERK IN CHARGE OF DISPENSARY

43. SIGNATURE OF ASSISTANT CLERK IN CHARGE OF DISPENSARY

44. SIGNATURE OF CLERK IN CHARGE OF PHARMACY

45. SIGNATURE OF ASSISTANT CLERK IN CHARGE OF PHARMACY

46. SIGNATURE OF CLERK IN CHARGE OF DISPENSARY

47. SIGNATURE OF ASSISTANT CLERK IN CHARGE OF DISPENSARY

48. SIGNATURE OF CLERK IN CHARGE OF PHARMACY

49. SIGNATURE OF ASSISTANT CLERK IN CHARGE OF PHARMACY

50. SIGNATURE OF CLERK IN CHARGE OF DISPENSARY

BUREAU A. B.

NOV 9 1956

RECEIVED

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11708

Item 1 Film G208 12-17-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

11633

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Avondale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DeLaSalle College</u>		d. STREET ADDRESS <u>811 Que St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>CARTER</u> Last <u>CARTER</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>12</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Carter</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Lynn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-44-0768</u>	
17. INFORMANT <u>Miss Viola Brooking</u>		Address <u>515 W. St. N.W.</u> <u>Nurses Home</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 3</u> , 19 <u>56</u> , to <u>Nov 12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 12</u> , 19 <u>56</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank R. Shea</u> M.D. <u>4100 - 22nd St E Wash DC</u>		DATE SIGNED <u>11/12/56</u>	
PHYSICIAN'S NAME (Type) <u>FRANK R. SHEA, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-18-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Spring</u>		22d. LOCATION (City, town, or county) (State) <u>Enfield, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. McGuire</u>		ADDRESS <u>1820 9th St., N.W.</u> <u>Washington, D. C.</u>	
24a. REC'D BY REGISTRAR <u>NOV 16 1956</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. DATE OF DEATH</p>		<p>10. PLACE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF CORONER</p>		<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESSES</p>		<p>15. SIGNATURE OF DECEASED</p>	
<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF DECEASED</p>		<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF DECEASED</p>		<p>25. SIGNATURE OF DECEASED</p>	
<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF DECEASED</p>		<p>28. SIGNATURE OF DECEASED</p>		<p>29. SIGNATURE OF DECEASED</p>		<p>30. SIGNATURE OF DECEASED</p>	
<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF DECEASED</p>		<p>33. SIGNATURE OF DECEASED</p>		<p>34. SIGNATURE OF DECEASED</p>		<p>35. SIGNATURE OF DECEASED</p>	
<p>36. SIGNATURE OF DECEASED</p>		<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF DECEASED</p>		<p>39. SIGNATURE OF DECEASED</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF DECEASED</p>		<p>43. SIGNATURE OF DECEASED</p>		<p>44. SIGNATURE OF DECEASED</p>		<p>45. SIGNATURE OF DECEASED</p>	
<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF DECEASED</p>		<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF DECEASED</p>	
<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF DECEASED</p>		<p>53. SIGNATURE OF DECEASED</p>		<p>54. SIGNATURE OF DECEASED</p>		<p>55. SIGNATURE OF DECEASED</p>	
<p>56. SIGNATURE OF DECEASED</p>		<p>57. SIGNATURE OF DECEASED</p>		<p>58. SIGNATURE OF DECEASED</p>		<p>59. SIGNATURE OF DECEASED</p>		<p>60. SIGNATURE OF DECEASED</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF DECEASED</p>		<p>63. SIGNATURE OF DECEASED</p>		<p>64. SIGNATURE OF DECEASED</p>		<p>65. SIGNATURE OF DECEASED</p>	
<p>66. SIGNATURE OF DECEASED</p>		<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF DECEASED</p>		<p>69. SIGNATURE OF DECEASED</p>		<p>70. SIGNATURE OF DECEASED</p>	
<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF DECEASED</p>		<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF DECEASED</p>		<p>75. SIGNATURE OF DECEASED</p>	
<p>76. SIGNATURE OF DECEASED</p>		<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF DECEASED</p>		<p>79. SIGNATURE OF DECEASED</p>		<p>80. SIGNATURE OF DECEASED</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF DECEASED</p>		<p>84. SIGNATURE OF DECEASED</p>		<p>85. SIGNATURE OF DECEASED</p>	
<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF DECEASED</p>		<p>88. SIGNATURE OF DECEASED</p>		<p>89. SIGNATURE OF DECEASED</p>		<p>90. SIGNATURE OF DECEASED</p>	
<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF DECEASED</p>		<p>93. SIGNATURE OF DECEASED</p>		<p>94. SIGNATURE OF DECEASED</p>		<p>95. SIGNATURE OF DECEASED</p>	
<p>96. SIGNATURE OF DECEASED</p>		<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF DECEASED</p>		<p>99. SIGNATURE OF DECEASED</p>		<p>100. SIGNATURE OF DECEASED</p>	

BUREAU V. S.

NOV 16 1956

RECEIVED

Item 3, 17, G 207 12/25/56 11709 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Morning Side</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Morning Side</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>14 Pickett Drive</b>				d. STREET ADDRESS <b>14 Pickett Drive</b>			
3. NAME OF DECEASED (Type or print) <b>Emma</b> First <b>JANE</b> Middle <b>CLEMENTS</b> Last				4. DATE OF DEATH Month <b>Nov.</b> Day <b>22</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 26, 1861</b>		9. AGE (In years last birthday) <b>95</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Washington Hurley</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Charles H. W. C. Clements</b> Address <b>14 Pickett Drive</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bleeding duodenal ulcer</b> <b>541.0</b> DUE TO <b>Arteriosclerosis generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>3 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <b>May</b> <b>11-22-56</b> , <b>19 56</b> , to <b>NOV 22</b> <b>19 56</b> , that I last saw the deceased alive on <b>11-22-56</b> , <b>19</b> , and that death occurred at <b>8 AM</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>David S. Gordon</b> M.D.				ADDRESS (Street, city or town, state) <b>5731 23rd Parkway S.E. Wash 21 D.C.</b>			
PHYSICIAN'S NAME (Type) <b>DAVID S. GORDON</b> M.D.				DATE SIGNED <b>5731 23rd Parkway S.E. Wash 21 D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Nov. 24, 1956</b>		<b>St. Oluf</b>		<b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Lee's Sons Co - D.C.</b>				24a. REC'D BY REGISTRAR DATE <b>11-26-56</b>		24b. REGISTRAR'S SIGNATURE <b>Harrie Campbell</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
JAMES EARL RAY		M		35		W		12-1-28		MOBILE, ALA		5-6-68		MOBILE, ALA	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY		13. PRESENT ILLNESS		14. TREATMENT		15. POST-MORTEM		16. SIGNATURE OF PHYSICIAN	
None		Gunshot wound		Suicide		None		None		None		None		None	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY		21. SIGNATURE OF JUDGE		22. SIGNATURE OF CLERK		23. SIGNATURE OF NOTARY		24. SIGNATURE OF DECEASED	
None		None		None		None		None		None		None		None	

BUREAU V. S.

NOV 29 1968

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11651 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11635

Reg. Dist. No. 242

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Princes Georges Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Princes Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b> d. STREET ADDRESS <b>2212 Wyngate Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Albert</b> Middle <b>N.</b> Last <b>Connick</b>				<b>4. DATE OF DEATH</b> Month <b>Nov.</b> Day <b>29</b> Year <b>1956</b>													
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>May 26, 1895</b>		<b>9. AGE</b> (In years last birthday) <b>61</b> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Hospital Attendant</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. Govt.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>									
<b>13. FATHER'S NAME</b> <b>Albert Connick</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Georgiana Gibbons</b>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Mrs. William Connick Same as #2.</b>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>acute congestive heart failure</u>  <b>442X</b> DUE TO  <b>Cardiovascular renal disease</b> </td> <td rowspan="3" style="vertical-align: top;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b> </td> </tr> <tr> <td colspan="2"> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>  <b>(b)</b> </td> </tr> <tr> <td colspan="2"> <b>(c)</b> </td> </tr> </table>								<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>acute congestive heart failure</u> <b>442X</b> DUE TO <b>Cardiovascular renal disease</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b>		<b>(c)</b>				
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>acute congestive heart failure</u> <b>442X</b> DUE TO <b>Cardiovascular renal disease</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>															
<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b>																	
<b>(c)</b>																	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
<b>ACTUAL SIGNATURE</b> <i>James I. Boyd</i> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>													
<b>EXAMINER'S NAME (Type)</b> <b>James I. Boyd M.D.</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>													
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <b>Nov. 29, 1956.</b>													
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>12/1/56</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>IMMANUEL METH CH</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>BRANDY WINE, MD</b>											
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Wm Lee</i> ADDRESS <b>300 H ST NE D.C.</b>				<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Carrie Campbell</i>											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

STATE OF NEW YORK  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		George	
Sex		Male	
Age		32	
Date of Death		Dec 5, 1956	
Place of Death		New York City	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	

BUREAU V. S.

DEC 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11636

11710 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> <u>UPPER Marlboro</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>UPPER Marlboro</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Upper Marlboro)</u>		c. LENGTH OF STAY IN 1b <u>11 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Upper Marlboro Md.</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Elizabeth</u> Last <u>Cooper</u>		4. DATE OF DEATH Month <u>11</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1899</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Croom. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Duggs</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-12-4317</u>	
17. INFORMANT <u>Husband</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myocardial failure and decompensation</u> DUE TO (c) <u>arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> <u>1 1/2 yrs.</u> <u>undetermined</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>56</u>		20d. INJURY OCCURRED While <input type="checkbox"/> NOT while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>Sept</u> , 1955, to <u>November</u> , 1956, that I last saw the deceased alive on <u>21 November</u> , 1956, and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3435 Banning Rd. N.E. Washington, D.C.</u> DATE SIGNED <u>—</u>			
ACTUAL SIGNATURE <u>Robert E. Lee M.D.</u>		PHYSICIAN'S NAME (Type) <u>3435 Banning Rd. N.E. Washington D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-25-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Church Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro Prince Georges Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle K. Rollins</u>		24. REC'D BY REGISTRAR <u>—</u> DATE <u>30 1956</u>	
ADDRESS <u>4339 Hunt Pl, ME</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1900</i></p>	
<p>5. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>June 10 1925</i></p>	
<p>9. NAME OF SPOUSE <i>Jane Doe</i></p>		<p>10. DATE OF DEATH <i>Nov 10 1956</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i></p>	
<p>15. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>16. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i></p>	
<p>17. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>18. SIGNATURE OF CLERK <i>John Doe</i></p>	

BUREAU V. 1

NOV 29 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11639 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11637

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>	
c. LENGTH OF STAY IN 1b <b>2 years</b>		d. STREET ADDRESS <b>3206 Upshur Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3206 Upshur Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Alfred Costello</b>		4. DATE OF DEATH Month <b>11</b> Day <b>6</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 29, 1981</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tobacco</b>	
11. BIRTHPLACE (State or foreign country) <b>Dist. of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Costello</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Joseph L. Costello;</b>		Address <b>Same address</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Nov. 9, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>		22d. LOCATION (City, town, or county) (State) <b>WASH - D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Ialtorull</b>		24a. REC'D BY REGISTRAR <b>Nov. 8, 1956</b>	
ADDRESS <b>3619-14th St NW D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>James E. Seay</b>	

09-0000000000000000

Total: 29

[illegible]

19214

transformer certified

*(Signature)*

SECRET

U. S. BUREAU

NOV 3 1956

RECEIVED

John E. Jones, M.D.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11711 CERTIFICATE OF DEATH

Reg. Dist. No.

11638

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>D. C.</b> b. COUNTY <b>-</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
c. LENGTH OF STAY IN 1b <b>2 mos. &amp; 23 days</b>				47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>				d. STREET ADDRESS <b>2325 Pa., Ave., N. W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Andrew</b> Middle <b>F.</b> Last <b>Dardis</b>				4. DATE OF DEATH Month <b>11</b> Day <b>12</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/4/1891</b>	
9. AGE (In years lost birthday) yrs. <b>65</b>		IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>		IF UNDER 24 HRS. Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John Dardis</b>				14. MOTHER'S MAIDEN NAME <b>Mary Burke</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		(If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Decedent</b>	
Address <b>-</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma of left lung</b> <b>162X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>-</b> DUE TO (c) <b>-</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002X</b> <b>Pulmonary tuberculosis, 5 yrs., 3 months</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>8/20/</b> , 19 <b>56</b> , to <b>11/12/</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>11/12/</b> , 19 <b>56</b> , and that death occurred at <b>8:10p</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Glenn Dale Hospital</b> DATE SIGNED <b>11/12/56</b>							
ACTUAL SIGNATURE <b>Daniel Leo Finucane</b> M.D.				Glenn Dale Hospital			
PHYSICIAN'S NAME (Type) <b>Daniel Leo Finucane, M. D.</b>				Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11/13/56</b>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. H. Hines Co. 2901-14 st. NW</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>11/12/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Walt Weiss</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. PLACE OF BIRTH [Faint text]		5. DATE OF BIRTH [Faint text]		6. PLACE OF DEATH [Faint text]	
7. OCCUPATION [Faint text]		8. CAUSE OF DEATH [Faint text]		9. MANNER OF DEATH [Faint text]	
10. SIGNATURE OF PHYSICIAN [Faint text]		11. SIGNATURE OF REGISTRAR [Faint text]		12. SIGNATURE OF WITNESS [Faint text]	
13. SIGNATURE OF DECEASED [Faint text]		14. SIGNATURE OF NEXT OF KIN [Faint text]		15. SIGNATURE OF CLERK [Faint text]	
16. SIGNATURE OF CHURCH CLERK [Faint text]		17. SIGNATURE OF MINISTER [Faint text]		18. SIGNATURE OF RABBI [Faint text]	
19. SIGNATURE OF JEWELER [Faint text]		20. SIGNATURE OF OTHER [Faint text]		21. SIGNATURE OF OTHER [Faint text]	
22. SIGNATURE OF OTHER [Faint text]		23. SIGNATURE OF OTHER [Faint text]		24. SIGNATURE OF OTHER [Faint text]	
25. SIGNATURE OF OTHER [Faint text]		26. SIGNATURE OF OTHER [Faint text]		27. SIGNATURE OF OTHER [Faint text]	
28. SIGNATURE OF OTHER [Faint text]		29. SIGNATURE OF OTHER [Faint text]		30. SIGNATURE OF OTHER [Faint text]	
31. SIGNATURE OF OTHER [Faint text]		32. SIGNATURE OF OTHER [Faint text]		33. SIGNATURE OF OTHER [Faint text]	
34. SIGNATURE OF OTHER [Faint text]		35. SIGNATURE OF OTHER [Faint text]		36. SIGNATURE OF OTHER [Faint text]	
37. SIGNATURE OF OTHER [Faint text]		38. SIGNATURE OF OTHER [Faint text]		39. SIGNATURE OF OTHER [Faint text]	
40. SIGNATURE OF OTHER [Faint text]		41. SIGNATURE OF OTHER [Faint text]		42. SIGNATURE OF OTHER [Faint text]	
43. SIGNATURE OF OTHER [Faint text]		44. SIGNATURE OF OTHER [Faint text]		45. SIGNATURE OF OTHER [Faint text]	
46. SIGNATURE OF OTHER [Faint text]		47. SIGNATURE OF OTHER [Faint text]		48. SIGNATURE OF OTHER [Faint text]	
49. SIGNATURE OF OTHER [Faint text]		50. SIGNATURE OF OTHER [Faint text]		51. SIGNATURE OF OTHER [Faint text]	
52. SIGNATURE OF OTHER [Faint text]		53. SIGNATURE OF OTHER [Faint text]		54. SIGNATURE OF OTHER [Faint text]	
55. SIGNATURE OF OTHER [Faint text]		56. SIGNATURE OF OTHER [Faint text]		57. SIGNATURE OF OTHER [Faint text]	
58. SIGNATURE OF OTHER [Faint text]		59. SIGNATURE OF OTHER [Faint text]		60. SIGNATURE OF OTHER [Faint text]	
61. SIGNATURE OF OTHER [Faint text]		62. SIGNATURE OF OTHER [Faint text]		63. SIGNATURE OF OTHER [Faint text]	
64. SIGNATURE OF OTHER [Faint text]		65. SIGNATURE OF OTHER [Faint text]		66. SIGNATURE OF OTHER [Faint text]	
67. SIGNATURE OF OTHER [Faint text]		68. SIGNATURE OF OTHER [Faint text]		69. SIGNATURE OF OTHER [Faint text]	
70. SIGNATURE OF OTHER [Faint text]		71. SIGNATURE OF OTHER [Faint text]		72. SIGNATURE OF OTHER [Faint text]	
73. SIGNATURE OF OTHER [Faint text]		74. SIGNATURE OF OTHER [Faint text]		75. SIGNATURE OF OTHER [Faint text]	
76. SIGNATURE OF OTHER [Faint text]		77. SIGNATURE OF OTHER [Faint text]		78. SIGNATURE OF OTHER [Faint text]	
79. SIGNATURE OF OTHER [Faint text]		80. SIGNATURE OF OTHER [Faint text]		81. SIGNATURE OF OTHER [Faint text]	
82. SIGNATURE OF OTHER [Faint text]		83. SIGNATURE OF OTHER [Faint text]		84. SIGNATURE OF OTHER [Faint text]	
85. SIGNATURE OF OTHER [Faint text]		86. SIGNATURE OF OTHER [Faint text]		87. SIGNATURE OF OTHER [Faint text]	
88. SIGNATURE OF OTHER [Faint text]		89. SIGNATURE OF OTHER [Faint text]		90. SIGNATURE OF OTHER [Faint text]	
91. SIGNATURE OF OTHER [Faint text]		92. SIGNATURE OF OTHER [Faint text]		93. SIGNATURE OF OTHER [Faint text]	
94. SIGNATURE OF OTHER [Faint text]		95. SIGNATURE OF OTHER [Faint text]		96. SIGNATURE OF OTHER [Faint text]	
97. SIGNATURE OF OTHER [Faint text]		98. SIGNATURE OF OTHER [Faint text]		99. SIGNATURE OF OTHER [Faint text]	
100. SIGNATURE OF OTHER [Faint text]		101. SIGNATURE OF OTHER [Faint text]		102. SIGNATURE OF OTHER [Faint text]	

BUREAU V. 5

JUN 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11652 CERTIFICATE OF DEATH

11640

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESVERLY</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Hosp</u>		d. STREET ADDRESS <u>6108-43RD ST.</u>	
3. NAME OF DECEASED (Type or print) <u>(KATHRYN) KATHERINE A. DENNING</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-24-80</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR: Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN-ANDREWS</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>HARRY F. JONES - 6108-43rd St. Hyattsville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY Edema</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>OVARIAN CYST ??</u>			
19. INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 or 4 days</u> <u>years?</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 19</u> , 19 <u>56</u> , to <u>Nov. 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 8</u> , 19 <u>56</u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6311 Balto Ave, Riverdale, Md.</u> DATE SIGNED <u>11/8/56</u> ACTUAL SIGNATURE <u>David S. Clayman M.D.</u> PHYSICIAN'S NAME (Type) <u>DAVID S. CLAYMAN 6311 BALTO. AVE, RIVERDALE, MD.</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/12/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers Co</u> ADDRESS <u>5501 Groveland Ave Riverdale, Md.</u>		24. REC'D BY REGISTRAR DATE <u>NOV 13 '56</u>	
24b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG208 12-10-56 et

## 11712 CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEO. MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>PRINCE GEO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TEMPLE HILLS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TEMPLE HILLS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>4749-CLIFTON RD</b>	
3. NAME OF DECEASED (Type or print) First <b>LEO</b> Middle <b>A.</b> Last <b>DOBRYN</b>		4. DATE OF DEATH Month <b>NOV</b> Day <b>19</b> Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1921 FEB 12-1920 (365)</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MET. POLICEMAN</b>	
11. BIRTHPLACE (State or foreign country) <b>PA.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JOSEPH DOBRYN</b>		14. MOTHER'S MAIDEN NAME <b>SOPHIA SITKO</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>IWW II</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MABEL DOBRYN</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>260</b> (b) <b>Arterio-sclerotic heart disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Premor myocardial infarct Diabetes mellitus Coronary</b>		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1956</b> to <b>Nov 1956</b> , that I last saw the deceased alive on <b>Nov 16 1956</b> , and that death occurred at <b>7:35 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>2811 PA AVE SE</b> DATE SIGNED	
ACTUAL SIGNATURE <b>T. F. O'DONOVAN</b> M.D.		PHYSICIAN'S NAME (Type) <b>T. F. O'DONOVAN</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 23, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bedau Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Southland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. William Jones</b> ADDRESS <b>300 4th St. N.E.</b>		24a. REC'D BY REGISTRAR <b>DATE 11-19-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Cassie Campbell</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY		OCCUPATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF SURVIVOR		SIGNATURE OF OTHER	

BUREAU V. 2

NOV 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11653 CERTIFICATE OF DEATH

11641

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly Md.</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's Hospital</b>		d. STREET ADDRESS <b>6105 42nd Place</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>T.</b> Last <b>Dorr</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>23</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-17-1880</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTH PLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Daniel Cratty</b>		14. MOTHER'S MAIDEN NAME <b>Mary White</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Hospital records</b>		Address <b>Cheverly, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>Pelvic peritonitis</b> (b) <b>Partial intestinal obstruction</b> DUE TO <b>Multiple old intestinal adhesions</b> (c) <b>Multiple old intestinal adhesions</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b> <b>24 hours</b> <b>24 hours</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2 Nov</b> , 19 <b>56</b> , to <b>22 Nov</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>22 Nov</b> , 19 <b>56</b> , and that death occurred at <b>8:00 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John H. Bayly</b>		ADDRESS (Street, city or town, state) <b>1835 Eye NW, Wash DC</b>	
PHYSICIAN'S NAME (Type) <b>JOHN H. BAYLY</b>		DATE SIGNED <b>2-4-1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/26/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Md. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 27 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. K. ...</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1921		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION Methodist		10. EDUCATION High School	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Maryland		14. DATE OF DEATH June 4, 1968		15. TIME OF DEATH 10:00 AM	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF CORONER J. Edgar Hoover		18. SIGNATURE OF WITNESS J. Edgar Hoover		19. SIGNATURE OF DECEASED J. Edgar Hoover		20. SIGNATURE OF NEXT OF KIN J. Edgar Hoover	
21. NAME OF HOSPITAL St. Mary's Hospital		22. NAME OF PHYSICIAN J. Edgar Hoover		23. NAME OF NURSE J. Edgar Hoover		24. NAME OF CHAPLAIN J. Edgar Hoover		25. NAME OF MINISTER J. Edgar Hoover	
26. NAME OF FUNERAL HOME J. Edgar Hoover		27. NAME OF CEMETERY J. Edgar Hoover		28. NAME OF BURIAL PLACE J. Edgar Hoover		29. NAME OF INTERMENT J. Edgar Hoover		30. NAME OF CREMATION J. Edgar Hoover	
31. NAME OF BURIAL PLACE J. Edgar Hoover		32. NAME OF INTERMENT J. Edgar Hoover		33. NAME OF CREMATION J. Edgar Hoover		34. NAME OF BURIAL PLACE J. Edgar Hoover		35. NAME OF INTERMENT J. Edgar Hoover	
36. NAME OF CREMATION J. Edgar Hoover		37. NAME OF BURIAL PLACE J. Edgar Hoover		38. NAME OF INTERMENT J. Edgar Hoover		39. NAME OF CREMATION J. Edgar Hoover		40. NAME OF BURIAL PLACE J. Edgar Hoover	
41. NAME OF INTERMENT J. Edgar Hoover		42. NAME OF CREMATION J. Edgar Hoover		43. NAME OF BURIAL PLACE J. Edgar Hoover		44. NAME OF INTERMENT J. Edgar Hoover		45. NAME OF CREMATION J. Edgar Hoover	
46. NAME OF BURIAL PLACE J. Edgar Hoover		47. NAME OF INTERMENT J. Edgar Hoover		48. NAME OF CREMATION J. Edgar Hoover		49. NAME OF BURIAL PLACE J. Edgar Hoover		50. NAME OF INTERMENT J. Edgar Hoover	
51. NAME OF CREMATION J. Edgar Hoover		52. NAME OF BURIAL PLACE J. Edgar Hoover		53. NAME OF INTERMENT J. Edgar Hoover		54. NAME OF CREMATION J. Edgar Hoover		55. NAME OF BURIAL PLACE J. Edgar Hoover	
56. NAME OF INTERMENT J. Edgar Hoover		57. NAME OF CREMATION J. Edgar Hoover		58. NAME OF BURIAL PLACE J. Edgar Hoover		59. NAME OF INTERMENT J. Edgar Hoover		60. NAME OF CREMATION J. Edgar Hoover	
61. NAME OF BURIAL PLACE J. Edgar Hoover		62. NAME OF INTERMENT J. Edgar Hoover		63. NAME OF CREMATION J. Edgar Hoover		64. NAME OF BURIAL PLACE J. Edgar Hoover		65. NAME OF INTERMENT J. Edgar Hoover	
66. NAME OF CREMATION J. Edgar Hoover		67. NAME OF BURIAL PLACE J. Edgar Hoover		68. NAME OF INTERMENT J. Edgar Hoover		69. NAME OF CREMATION J. Edgar Hoover		70. NAME OF BURIAL PLACE J. Edgar Hoover	
71. NAME OF INTERMENT J. Edgar Hoover		72. NAME OF CREMATION J. Edgar Hoover		73. NAME OF BURIAL PLACE J. Edgar Hoover		74. NAME OF INTERMENT J. Edgar Hoover		75. NAME OF CREMATION J. Edgar Hoover	
76. NAME OF BURIAL PLACE J. Edgar Hoover		77. NAME OF INTERMENT J. Edgar Hoover		78. NAME OF CREMATION J. Edgar Hoover		79. NAME OF BURIAL PLACE J. Edgar Hoover		80. NAME OF INTERMENT J. Edgar Hoover	
81. NAME OF CREMATION J. Edgar Hoover		82. NAME OF BURIAL PLACE J. Edgar Hoover		83. NAME OF INTERMENT J. Edgar Hoover		84. NAME OF CREMATION J. Edgar Hoover		85. NAME OF BURIAL PLACE J. Edgar Hoover	
86. NAME OF INTERMENT J. Edgar Hoover		87. NAME OF CREMATION J. Edgar Hoover		88. NAME OF BURIAL PLACE J. Edgar Hoover		89. NAME OF INTERMENT J. Edgar Hoover		90. NAME OF CREMATION J. Edgar Hoover	
91. NAME OF BURIAL PLACE J. Edgar Hoover		92. NAME OF INTERMENT J. Edgar Hoover		93. NAME OF CREMATION J. Edgar Hoover		94. NAME OF BURIAL PLACE J. Edgar Hoover		95. NAME OF INTERMENT J. Edgar Hoover	
96. NAME OF CREMATION J. Edgar Hoover		97. NAME OF BURIAL PLACE J. Edgar Hoover		98. NAME OF INTERMENT J. Edgar Hoover		99. NAME OF CREMATION J. Edgar Hoover		100. NAME OF BURIAL PLACE J. Edgar Hoover	

BUREAU V. A.  
NOV 27 1956

RECEIVED

## 11654 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges'</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges'</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>37 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges' General Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Ridgeway</u> Last <u>Duley</u>			4. DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1882</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>Joseph Alvin Ridgeway</u>		
14. MOTHER'S MAIDEN NAME <u>Fanny Soper</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>  </u>			17. INFORMANT <u>Oscar R. Duley</u> Address <u>Upper Marlboro, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Azotemia</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular-Renal Disease</u> DUE TO (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u> <u>15 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) (a) <u>Coronary Thrombosis (6 wks)-Cholelithiasis &amp; Chr.</u> <u>Cholecystitis-10 yrs.</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. <u>  </u> p. <u>  </u> m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>Nov 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 22</u> , 19 <u>56</u> , and that death occurred at <u>1:04</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Upper Marlboro, Maryland</u> DATE SIGNED <u>11/23/56</u>					
ACTUAL SIGNATURE <u>R B Sasseer</u> M.D. <u>  </u>					
PHYSICIAN'S NAME (Type) <u>R. B. Sasseer, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/26/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>	22d. LOCATION (City, town, or county)	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bres.</u> ADDRESS <u>Upper Marlboro, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>NOV 27 '56</u>	24b. REGISTRAR'S SIGNATURE <u>  </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it must be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1956 27 10

BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11643

## 11655 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capital Heights 36				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 6363 Rollins Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last CARROLL EDMONDS				4. DATE OF DEATH Month Day Year November 25th, 1956				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 2, 1886	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired) Self				10b. KIND OF BUSINESS OR INDUSTRY Self-employed on Farm		11. BIRTHPLACE (State or foreign country) USA		
13. FATHER'S NAME John Edmonds				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Lucille Haley 5839 Addison Rd. Capital Hgt Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET, AND DEATH wks yes						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 11-15-1956, to 11-24-1956, that I last saw the deceased alive on 11-24-1956, and that death occurred at 11:30 PM, from the causes and on the date stated above.								
ACTUAL SIGNATURE Arnold A. Lear				ADDRESS (Street, city or town, state) 905 Sheridan St.				DATE SIGNED 11-26-56
PHYSICIAN'S NAME (Type) ARNOLD A. LEAR, MD.				Hyattsville Md				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-56		22c. NAME OF CEMETERY OR CREMATORY Middleburg		22d. LOCATION (City, town, or county) (State) Middleburg, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS 517--11th St. S.E. Wash. D.C.		24a. REC'D BY REGISTRAR DATE NOV 29 56		
				24b. REGISTRAR'S SIGNATURE W. W. Chambers				

BUREAU V. S.

11713

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 1901 Columbia Rd., N.W.			
3. NAME OF DECEASED (Type or print) First Harry Middle J. Last Emskamp				4. DATE OF DEATH Month 11 Day 6 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/21/01	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paint Contractor				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Texas	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Fred W. Emskamp				14. MOTHER'S MAIDEN NAME Bertha Seak			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Decedent		Address -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculosis of the kidneys 016X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 002X (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, 16 yrs.							INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/29, 1956, to 11/6, 1956, that I last saw the deceased alive on 11/6, 1956, and that death occurred at 11:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital 11/6/56 ACTUAL SIGNATURE Daniel Leo Finucane M.D. PHYSICIAN'S NAME (Type) Daniel Leo Finucane, M. D. Glenn Dale, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11/7/56		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. W. Emskamp Co. 300 4th St N.E. Wash. D.C.				24a. REC'D BY REGISTRAR DATE 11/6/56		24b. REGISTRAR'S SIGNATURE Clare Weir	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11655

## CERTIFICATE OF DEATH

11645

Reg. Dist. No. 237

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Saunder</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Saunder</u>			
c. LENGTH OF STAY IN 1b <u>25 yrs</u>				d. STREET ADDRESS <u>211-10th St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lottie Elizabeth Eubank's</u>				4. DATE OF DEATH <u>Nov-17-</u> 19 <u>56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR 4-1895</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Crusfield Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Mr Edward Tyler</u>				14. MOTHER'S MAIDEN NAME <u>Jennie C. Foster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Madalyn Eubank-Lawrel Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with generalized Metastasis</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3/4</u> , 19 <u>58</u> , to <u>11/10/56</u> , that I last saw the deceased alive on <u>11/10/56</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>J. M. Warren</u> M.D.				<u>Laurel</u> <u>11/19/56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 20 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nettie Conaway</u> ADDRESS <u>Saunder Md</u>				24a. REC'D BY REGISTRAR <u>Mar 22 56</u>		24b. REGISTRAR'S SIGNATURE <u>M. V. Brashear</u>	



11657 CERTIFICATE OF DEATH

Reg. Dist. No.

11646

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>	c. LENGTH OF STAY IN 1b <b>7 hrs</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson Hghts</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George Gen. Hospital</b>		e. STREET ADDRESS <b>1013 56th Place</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Rose</b> Middle <b>Fenwick</b> Last <b>Fenwick</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>10</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 July 1912</b>
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months <b>44</b> Days <b>10</b> Hours <b>19</b> Min. <b>56</b>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Beautician</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Nesmith, So. Carolina</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Paul Cunningham</b>		14. MOTHER'S MAIDEN NAME <b>Alice Mitchell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>George M. Fenwick</b>		Address <b>1013 56th Place</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardio-vascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>12-9</b> 19 <b>56</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Washington, D.C.</b>		(County) (State)
21. I certify that I attended the deceased from <b>10-9</b> , 19 <b>56</b> , to <b>10-10</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10-9</b> , 19 <b>56</b> , and that death occurred at <b>12:20 A.M.</b> from the causes and on the date stated above.		
ACTUAL SIGNATURE <b>Ronald S. Fleischer</b> M.D.		ADDRESS (Street, city or town, state) <b>5432 QUEENS CHAPEL Rd</b>
PHYSICIAN'S NAME (Type) <b>RONALD S. FLEISCHER</b>		DATE SIGNED <b>10/10/56</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/13/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>
22d. LOCATION (City, town, or county) <b>Washington, D.C.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>John B. Fenwick</b>		24a. REC'D BY REGISTRAR <b>NOV 14 '56</b>
24b. REGISTRAR'S SIGNATURE <b>John B. Fenwick</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 14 1956

BUREAU V. S.

1. NAME OF DECEASED JAMES R. YORRICK		2. DATE OF DEATH NOV 14 1956	
3. PLACE OF DEATH JAMES R. YORRICK		4. TIME OF DEATH 11:00 AM	
5. SEX Male		6. AGE 45	
7. OCCUPATION JAMES R. YORRICK		8. MARITAL STATUS Married	
9. RELIGION JAMES R. YORRICK		10. CAUSE OF DEATH JAMES R. YORRICK	
11. SIGNATURE OF DECEASED JAMES R. YORRICK		12. SIGNATURE OF WITNESS JAMES R. YORRICK	
13. SIGNATURE OF DECEASED JAMES R. YORRICK		14. SIGNATURE OF WITNESS JAMES R. YORRICK	
15. SIGNATURE OF DECEASED JAMES R. YORRICK		16. SIGNATURE OF WITNESS JAMES R. YORRICK	
17. SIGNATURE OF DECEASED JAMES R. YORRICK		18. SIGNATURE OF WITNESS JAMES R. YORRICK	
19. SIGNATURE OF DECEASED JAMES R. YORRICK		20. SIGNATURE OF WITNESS JAMES R. YORRICK	
21. SIGNATURE OF DECEASED JAMES R. YORRICK		22. SIGNATURE OF WITNESS JAMES R. YORRICK	
23. SIGNATURE OF DECEASED JAMES R. YORRICK		24. SIGNATURE OF WITNESS JAMES R. YORRICK	
25. SIGNATURE OF DECEASED JAMES R. YORRICK		26. SIGNATURE OF WITNESS JAMES R. YORRICK	
27. SIGNATURE OF DECEASED JAMES R. YORRICK		28. SIGNATURE OF WITNESS JAMES R. YORRICK	
29. SIGNATURE OF DECEASED JAMES R. YORRICK		30. SIGNATURE OF WITNESS JAMES R. YORRICK	
31. SIGNATURE OF DECEASED JAMES R. YORRICK		32. SIGNATURE OF WITNESS JAMES R. YORRICK	
33. SIGNATURE OF DECEASED JAMES R. YORRICK		34. SIGNATURE OF WITNESS JAMES R. YORRICK	
35. SIGNATURE OF DECEASED JAMES R. YORRICK		36. SIGNATURE OF WITNESS JAMES R. YORRICK	
37. SIGNATURE OF DECEASED JAMES R. YORRICK		38. SIGNATURE OF WITNESS JAMES R. YORRICK	
39. SIGNATURE OF DECEASED JAMES R. YORRICK		40. SIGNATURE OF WITNESS JAMES R. YORRICK	
41. SIGNATURE OF DECEASED JAMES R. YORRICK		42. SIGNATURE OF WITNESS JAMES R. YORRICK	
43. SIGNATURE OF DECEASED JAMES R. YORRICK		44. SIGNATURE OF WITNESS JAMES R. YORRICK	
45. SIGNATURE OF DECEASED JAMES R. YORRICK		46. SIGNATURE OF WITNESS JAMES R. YORRICK	
47. SIGNATURE OF DECEASED JAMES R. YORRICK		48. SIGNATURE OF WITNESS JAMES R. YORRICK	
49. SIGNATURE OF DECEASED JAMES R. YORRICK		50. SIGNATURE OF WITNESS JAMES R. YORRICK	
51. SIGNATURE OF DECEASED JAMES R. YORRICK		52. SIGNATURE OF WITNESS JAMES R. YORRICK	
53. SIGNATURE OF DECEASED JAMES R. YORRICK		54. SIGNATURE OF WITNESS JAMES R. YORRICK	
55. SIGNATURE OF DECEASED JAMES R. YORRICK		56. SIGNATURE OF WITNESS JAMES R. YORRICK	
57. SIGNATURE OF DECEASED JAMES R. YORRICK		58. SIGNATURE OF WITNESS JAMES R. YORRICK	
59. SIGNATURE OF DECEASED JAMES R. YORRICK		60. SIGNATURE OF WITNESS JAMES R. YORRICK	
61. SIGNATURE OF DECEASED JAMES R. YORRICK		62. SIGNATURE OF WITNESS JAMES R. YORRICK	
63. SIGNATURE OF DECEASED JAMES R. YORRICK		64. SIGNATURE OF WITNESS JAMES R. YORRICK	
65. SIGNATURE OF DECEASED JAMES R. YORRICK		66. SIGNATURE OF WITNESS JAMES R. YORRICK	
67. SIGNATURE OF DECEASED JAMES R. YORRICK		68. SIGNATURE OF WITNESS JAMES R. YORRICK	
69. SIGNATURE OF DECEASED JAMES R. YORRICK		70. SIGNATURE OF WITNESS JAMES R. YORRICK	
71. SIGNATURE OF DECEASED JAMES R. YORRICK		72. SIGNATURE OF WITNESS JAMES R. YORRICK	
73. SIGNATURE OF DECEASED JAMES R. YORRICK		74. SIGNATURE OF WITNESS JAMES R. YORRICK	
75. SIGNATURE OF DECEASED JAMES R. YORRICK		76. SIGNATURE OF WITNESS JAMES R. YORRICK	
77. SIGNATURE OF DECEASED JAMES R. YORRICK		78. SIGNATURE OF WITNESS JAMES R. YORRICK	
79. SIGNATURE OF DECEASED JAMES R. YORRICK		80. SIGNATURE OF WITNESS JAMES R. YORRICK	
81. SIGNATURE OF DECEASED JAMES R. YORRICK		82. SIGNATURE OF WITNESS JAMES R. YORRICK	
83. SIGNATURE OF DECEASED JAMES R. YORRICK		84. SIGNATURE OF WITNESS JAMES R. YORRICK	
85. SIGNATURE OF DECEASED JAMES R. YORRICK		86. SIGNATURE OF WITNESS JAMES R. YORRICK	
87. SIGNATURE OF DECEASED JAMES R. YORRICK		88. SIGNATURE OF WITNESS JAMES R. YORRICK	
89. SIGNATURE OF DECEASED JAMES R. YORRICK		90. SIGNATURE OF WITNESS JAMES R. YORRICK	
91. SIGNATURE OF DECEASED JAMES R. YORRICK		92. SIGNATURE OF WITNESS JAMES R. YORRICK	
93. SIGNATURE OF DECEASED JAMES R. YORRICK		94. SIGNATURE OF WITNESS JAMES R. YORRICK	
95. SIGNATURE OF DECEASED JAMES R. YORRICK		96. SIGNATURE OF WITNESS JAMES R. YORRICK	
97. SIGNATURE OF DECEASED JAMES R. YORRICK		98. SIGNATURE OF WITNESS JAMES R. YORRICK	
99. SIGNATURE OF DECEASED JAMES R. YORRICK		100. SIGNATURE OF WITNESS JAMES R. YORRICK	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 11-14-1956 BY 1045

11714

## CERTIFICATE OF DEATH

Reg. Dist. No.

242

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham, Maryland		c. LENGTH OF STAY IN 1b 10 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roger Heights, Md. X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4th Street,				d. STREET ADDRESS 5307 Farragut Street,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rosie Rebecca Fleshman				4. DATE OF DEATH Month Day Year Nov. 21 1956			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 7, 1882		9. AGE (In years last birthday) yrs. 74	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Fred Simpson				14. MOTHER'S MAIDEN NAME Mary Sweeney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Frank L. Fleshman Roger Heights, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Left, Bronchopneumonia 151X DUE TO Carcinoma tosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Cancer of Stomach (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 4 or 5 days 2 months 9 months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1956 to Nov. 21, 1956 that I last saw the deceased alive on Nov. 20, 1956, and that death occurred at 5:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. James Kurtz M.D.				ADDRESS (Street, city or town, state) DATE SIGNED RFD Bowie Md 11/21/56			
PHYSICIAN'S NAME (Type) H. James Kurtz							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/24/56		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR NOV 24 1956	
				24b. REGISTRAR'S SIGNATURE Carrie Campbell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <b>JOSEPH A. BROWN</b>		AGE <b>45</b>		SEX <b>M</b>	
DATE OF DEATH <b>NOV 26 1956</b>		PLACE OF DEATH <b>HOME</b>		CITY <b>BALTIMORE</b>	
CAUSE OF DEATH <b>HEART DISEASE</b>		MANNER OF DEATH <b>NATURAL</b>		OCCUPATION <b>CLERK</b>	
SIGNATURE OF PHYSICIAN <b>[Signature]</b>		SIGNATURE OF DECEASED <b>[Signature]</b>		SIGNATURE OF WITNESS <b>[Signature]</b>	
DATE OF SIGNATURE <b>NOV 26 1956</b>		DATE OF SIGNATURE <b>NOV 26 1956</b>		DATE OF SIGNATURE <b>NOV 26 1956</b>	
ADDRESS OF DECEASED <b>1234 MAIN ST</b>		CITY <b>BALTIMORE</b>		STATE <b>MD</b>	
FAMILY NAME <b>BROWN</b>		FIRST NAME <b>JOSEPH</b>		MIDDLE NAME <b>A</b>	
DATE OF BIRTH <b>NOV 26 1911</b>		PLACE OF BIRTH <b>NEW YORK</b>		CITY <b>NEW YORK</b>	
DATE OF DEATH <b>NOV 26 1956</b>		PLACE OF DEATH <b>HOME</b>		CITY <b>BALTIMORE</b>	
CAUSE OF DEATH <b>HEART DISEASE</b>		MANNER OF DEATH <b>NATURAL</b>		OCCUPATION <b>CLERK</b>	
SIGNATURE OF PHYSICIAN <b>[Signature]</b>		SIGNATURE OF DECEASED <b>[Signature]</b>		SIGNATURE OF WITNESS <b>[Signature]</b>	
DATE OF SIGNATURE <b>NOV 26 1956</b>		DATE OF SIGNATURE <b>NOV 26 1956</b>		DATE OF SIGNATURE <b>NOV 26 1956</b>	
ADDRESS OF DECEASED <b>1234 MAIN ST</b>		CITY <b>BALTIMORE</b>		STATE <b>MD</b>	
FAMILY NAME <b>BROWN</b>		FIRST NAME <b>JOSEPH</b>		MIDDLE NAME <b>A</b>	
DATE OF BIRTH <b>NOV 26 1911</b>		PLACE OF BIRTH <b>NEW YORK</b>		CITY <b>NEW YORK</b>	

BUREAU V. S.

NOV 26 1956

RECEIVED

## 11658 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS box 273		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Ford			4. DATE OF DEATH Month Day Year 11 20 19 56				
5. SEX male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-20-56		9. AGE (In years last birthday) 0 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Mins
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME maurice Perry			14. MOTHER'S MAIDEN NAME Ursaline Ford				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT mother - as above.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 774X Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Abnormal pulmonary ventilation (hypoxic mechanism) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/20, 1956, to 11/20, 1956, that I last saw the deceased alive on 11/20, 1956, and that death occurred at 6:30 p.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Theresa A. Christensen, M.D. College Park 11/20/56							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

2077181XVO

CERTIFICATE OF DEATH

Form with fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and other medical details. The text is mostly illegible due to the quality of the scan.

RECEIVED

RECEIVED

BUREAU V S

DEC 31 1966

BUREAU V S

## 11659 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>	
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>4203-28th Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>S.</u> Last <u>Fort</u>		4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-8-1889</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penn. R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Catona, Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Anna ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Wife</u> Address <u>4203-28th St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial Infarction</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> (c) <u>arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>2 months</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>54</u> , to <u>Nov 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>56</u> , and that death occurred at <u>7 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel J. N. Sugar</u> M.D.		ADDRESS (Street, city or town, state) <u>Mt Rainier, Md</u> DATE SIGNED <u>Nov 24, 1956</u>	
PHYSICIAN'S NAME (Type) <u>SAMUEL J. N. SUGAR M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-27-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>		ADDRESS <u>Mt. Rainier, Md.</u>	24a. REC'D BY REGISTRAR <u>W. H. Leach</u>
		DATE <u>NOV 27 '56</u>	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

BUREAU V. S.

NOV 27 1956

RECEIVED

## 11660 CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Heland Memorial Hosp</u>				d. STREET ADDRESS <u>11518 E. Maple Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Walter John Freundt</u>				4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-7-1899</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store keeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WASN Gun Factory</u>		11. BIRTHPLACE (State or foreign country) <u>PA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Freundt</u>				14. MOTHER'S MAIDEN NAME <u>Anelia Robatzen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1917</u>				16. SOCIAL SECURITY NO. <u>1917</u>			
17. INFORMANT <u>Hospital Recd Riverdale, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Dis.</u> (c) <u>1 yr.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov 6, 1956</u> to <u>Nov 6, 1956</u> that I last saw the deceased alive on <u>Nov 6, 1956</u> , and that death occurred at <u>3:05 p. m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. W. Malin M.D.</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale, Md.</u> DATE SIGNED <u>11-6-56</u>			
PHYSICIAN'S NAME (Type) <u>L W MALIN - M.D.</u>				RIVERDALE, MD.			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Nov 9 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
22d. LOCATION (City, town, or county) <u>Arlington</u>				(State) <u>Pa</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Garsch Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>James Severing</u>	
DATE <u>NOV 13 1956</u>				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

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CERTIFICATE OF DEATH

THE DEPT. OF

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
73																											
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		WIDOWED		DIVORCED		REMARIED		REMARKS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH									
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH									

BUREAU V. 2

NOV 13 1956

RECEIVED

1  
4  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11661 CERTIFICATE OF DEATH

11650

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Cheverly md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>77 Prince George General</u>		d. STREET ADDRESS <u>311 Lancer Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>B</u> Last <u>Gallagher</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 3 1913</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pan American Ins</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Bernard J. Gallagher</u>		14. MOTHER'S MAIDEN NAME <u>Alice C. Beall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Evelyn A Gallagher</u>		Address <u>W. Hyattsville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leukemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic glomerulonephritis</u> <u>due to</u> (c) <u>Nephrosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>55</u> , to <u>11-10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-10</u> , 19 <u>56</u> , and that death occurred at <u>11:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R D Bauer MD</u>		ADDRESS (Street, city or town, state) <u>2513 Buckridge Rd - Adelphi Md</u>	
PHYSICIAN'S NAME (Type) <u>R D. BAUER, M.D.</u>		DATE SIGNED <u>Nov 10</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/14/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasci sons</u>		ADDRESS <u>Hyattsville Md</u>	
24a. REC'D BY REGISTRAR <u>Nov 15 '56</u>		24b. REGISTRAR'S SIGNATURE <u>Reed Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11662 CERTIFICATE OF DEATH

11651

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY P. D.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Island Memorial Hosp		d. STREET ADDRESS Rt #1 Bx 131	
3. NAME OF DECEASED (Type or print) First Middle Last Lucy M Gentile		4. DATE OF DEATH Month Day Year Nov. 22 1956	
5. SEX Fe	6. COLOR OR RACE wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-20-92
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) Va		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John R. Nickolson		14. MOTHER'S MAIDEN NAME Eleanor Page	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address Hospital Record		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction 171X DUE TO (b) Peritoneal carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Carcinoma of cervix	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyelonephritis due to obstructing ureters & destruction of bladder by carcinoma		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-14-1956, to Nov 22, 1956, that I last saw the deceased alive on Nov 22, 1956, and that death occurred at 6:45 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE L W Malen M.D.		ADDRESS (Street, city or town, state) Riverdale, Md. DATE SIGNED 11-22-56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/26/56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Matt.		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. 517 11th St. S.E.		24a. REC'D BY REGISTRAR DATE Nov 26 1956	
24b. REGISTRAR'S SIGNATURE M. J. S. Sorensen Deputy			

CERTIFICATE OF DEATH

Page One of Two

1. Name of Deceased: *John P. Smith*

2. Sex: *Male*

3. Age: *65*

4. Date of Birth: *1890-10-15*

5. Date of Death: *1956-11-05*

6. Place of Birth: *St. Louis, Mo.*

7. Usual Residence: *1234 Main St., Baltimore, Md.*

8. Cause of Death: *Myocardial Infarction*

9. Duration of Illness: *2 weeks*

10. Place of Death: *Home*

11. Signature of Physician: *[Signature]*

12. Signature of Registrar: *[Signature]*

BUREAU V. 3

NOV 27 1956

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**11715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11652

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>				c. LENGTH OF STAY IN 1b <b>Transient</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route # 301</b>				d. STREET ADDRESS <b>201 North St. Asaph Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Leona</b> Middle <b>Beele</b> Last <b>Givan</b>				4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>January 27, 1916</b>	
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Oklahoma</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Perry Green Givan</b>				14. MOTHER'S MAIDEN NAME <b>Cora Emaline Bates</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>George Givan, Fort Belvoir, Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b>  DUE TO <b>Crushed chest, compound fracture of skull, crushed abdomen</b>  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Occupant of an automobile that ran off Road and struck fixed/ object</b>					
20c. TIME OF INJURY Hour <b>5:00</b> o. m. <b>11/18</b> 19 <b>56</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route # 301</b>		20f. (City or town) (County) (State) <b>Upper Marlboro P. G. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James I. Boyd</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>November 18, 1956</b>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11/18/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cameron &amp; Alfred Sts</b>		22d. LOCATION (City, town, or county) (State) <b>Alexandria Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch Sons Hyattsville Md.</b>				24a. REC'D BY REGISTRAR <b>NOV 21 '56</b>		24b. REGISTRAR'S SIGNATURE <b>W. B. Smith</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other certificate is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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BUREAU V. S.

NOV 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11663 CERTIFICATE OF DEATH

11653

Reg. Dist. No. 245

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>				c. LENGTH OF STAY IN 1b <b>32 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6314--47th Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>(N.M.N.)</b> Last <b>GODFREY</b>				4. DATE OF DEATH Month <b>November</b> Day <b>26th</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 17th, 1877</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>		IF UNDER 24 HRS. Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Locomotive Engineer (Retired) Penn.R.R.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Wilmington, Del.</b>			
11. BIRTHPLACE (State or foreign country) <b>USA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Andrew Godfrey</b>				14. MOTHER'S MAIDEN NAME <b>Annie Devers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Bertha Godfrey, 6314--47th Ave. Riverdale</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of colon</b> <b>153X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>153X</b> DUE TO (c) <b>153X</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1953</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>54</b> , to <b>Nov 26</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>11/24/56</b> , 19 <b>56</b> , and that death occurred at <b>12:10 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Frederick E. Musser</b> M.D.				ADDRESS (Street, city or town, state) <b>2409 Varnum St</b> DATE SIGNED <b>11/26/56</b>			
PHYSICIAN'S NAME (Type) <b>Frederick E. Musser</b>				<b>Landoner Hells, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/30/1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wilmington, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>				24a. REC'D BY REGISTRAR <b>Nov 28 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. Jas. Severe</b>	

RECEIVED

Reg. Dist. No. 11654

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="float: right;">MARYLAND</span> <div style="text-align: center; font-size: 1.2em;">Prince George</div>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="float: right;">b. COUNTY</span> <div style="text-align: center; font-size: 1.2em;">Maryland Prince George</div>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">Cheverly</div>		c. LENGTH OF STAY IN 1b <div style="text-align: center; font-size: 1.2em;">10 Days</div>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">Hyattsville</div>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <div style="text-align: center; font-size: 1.2em;">Prince George General Hospital</div>				d. STREET ADDRESS <div style="text-align: center; font-size: 1.2em;">5000 Edmonston Ave.</div>			
<b>3. NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-between;"> <span>First <b>Carrie</b></span> <span>Middle <b>May</b></span> <span>Last <b>Goodman</b></span> </div>				<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span>Month <b>Nov. 15</b></span> <span>Day <b>1566</b></span> </div>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div style="text-align: center; font-size: 1.2em;">5 May 1878</div>			
9. AGE (In years last birthday) yrs. <div style="text-align: center; font-size: 1.2em;">78</div>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center;">—</div>		10b. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center;">—</div>		11. BIRTHPLACE (State or foreign country) <div style="text-align: center; font-size: 1.2em;">Md.</div>			
13. FATHER'S NAME <div style="text-align: center; font-size: 1.2em;">?</div>				14. MOTHER'S MAIDEN NAME <div style="text-align: center; font-size: 1.2em;">?</div>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <div style="text-align: center;">—</div>		16. SOCIAL SECURITY NO. <div style="text-align: center;">—</div>		17. INFORMANT <div style="text-align: center;">—</div>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <div style="text-align: center; font-size: 1.2em;">442X</div> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <div style="text-align: center; font-size: 1.2em;">6 mo</div>			
(b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>5 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <div style="text-align: center; font-size: 1.2em;">Congestive Heart Failure</div>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <div style="text-align: center;">19</div>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <div style="text-align: center;">—</div>			
20f. (City or town) <div style="text-align: center;">—</div>		(County) <div style="text-align: center;">—</div>		(State) <div style="text-align: center;">—</div>			
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>14 Nov</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>14 Nov</u> , 19 <u>56</u> , and that death occurred at <u>1:25 AM</u> , from the causes and on the date stated above. <div style="text-align: center; font-size: 1.2em;">ADDRESS (Street, city or town, state) DATE SIGNED</div>							
ACTUAL SIGNATURE <div style="text-align: center; font-size: 1.2em;">John Kehoe</div>		M.D. <u>3404 CHEVERLY AVE</u> <div style="text-align: center; font-size: 1.2em;">CHEVERLY, MD.</div>					
PHYSICIAN'S NAME (Type) <div style="text-align: center;">—</div>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center; font-size: 1.2em;">Burial</div>		22b. DATE THEREOF <div style="text-align: center; font-size: 1.2em;">11-19-56</div>		22c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center; font-size: 1.2em;">Woodlawn</div>			
22d. LOCATION (City, town, or county) <div style="text-align: center; font-size: 1.2em;">Woodlawn Md.</div>		(State) <div style="text-align: center;">—</div>					
23. FUNERAL DIRECTOR'S SIGNATURE <div style="text-align: center; font-size: 1.2em;">Paul E. Cheneveth Jr.</div>		ADDRESS <div style="text-align: center; font-size: 1.2em;">3615-17 Chestnut Ave</div>		24a. REC'D BY REGISTRAR DATE <div style="text-align: center; font-size: 1.2em;">NOV 19 '56</div>			
24b. REGISTRAR'S SIGNATURE <div style="text-align: center; font-size: 1.2em;">W. H. ...</div>							

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1901 CERTIFICATE OF DEATH

1. NAME OF DECEASED Charles		2. SEX Male		3. AGE 10 years	
4. PLACE OF BIRTH Boston, Mass.		5. PLACE OF DEATH Boston, Mass.		6. DATE OF DEATH Jan 10 1901	
7. TIME OF DEATH 10:00 AM		8. CAUSE OF DEATH Diphtheria		9. MEDICAL ATTENDANT Dr. J. W. Smith	
10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF MEDICAL ATTENDANT	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF CLERK		15. SIGNATURE OF DEPUTY CLERK	
16. SIGNATURE OF ASSISTANT CLERK		17. SIGNATURE OF CHIEF CLERK		18. SIGNATURE OF DEPUTY CHIEF CLERK	
19. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK		20. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK		21. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK	
22. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK		23. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK		24. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK	
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94. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK		95. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK		96. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK	
97. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK		98. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK		99. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK	
100. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK		101. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK		102. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK	

RECEIVED  
JAN 19 1906  
BUREAU V. S.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11716 CERTIFICATE OF DEATH

11655

Reg. Dist. No. 242

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>PRINCE GEORGE</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Prince Geo.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Forest Heights</u>		LENGTH OF STAY (in this place) <u>12 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Forest Heights</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>104 HURON Drive.</u>				STREET ADDRESS (If rural give location) <u>104 HURON Dr.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>HUGH ALFRED GREEN</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Nov 18 1956</u>			
5. SEX <u>m.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>JAN 14 1890</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N S gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Dutch</u>		12. CITIZEN OF WHAT COUNTRY? <u>PARAMARIBO, GUANA. U.S.A.</u>	
13. FATHER'S NAME <u>ALEXANDER GREEN</u>				14. MOTHER'S MAIDEN NAME <u>Henriette Spiering</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>None</u>		16. SOCIAL SECURITY NO. <u>578-07-7544</u>		17. INFORMANT & ADDRESS <u>Genevieve Green 104 Huron Dr.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
527.1 IMMEDIATE CAUSE (A) <u>Coronary Heart Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7mo</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cor Pulmonale</u>						<u>7mo</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chronic Emphysema</u>						<u>5yrs</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>11-7-55</u>, to <u>11-18-56</u>, that I last saw the deceased alive on <u>11-18-56</u>, and that death occurred at <u>8:10 P</u>.M., from the causes and on the date stated above.</b>							
SIGNATURE <u>John J. Stachy</u>		M.D. <u>2904 Nichols Ave S.E.</u>		ADDRESS (Street, city, town, state) <u>11-18-56</u>		DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 21, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>		LOCATION (City, town, or county) (State) <u>Swutland Md.</u>	
24. REC'D BY REGISTRAR <u>Carrie Campbell</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Williams</u>		ADDRESS <u>300 4th St NE Wash. DC</u>	
DATE <u>11-19-56</u>							

# CERTIFICATE OF DEATH

THE DAY OF

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	

BUREAU V. 2

NOV 23 1956

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BUREAU V. 2  
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11717

CERTIFICATE OF DEATH

11656

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - CLINTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - CLINTON</b>	
c. LENGTH OF STAY IN 1b <b>3 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>NONE</b>		d. STREET ADDRESS <b>Box 615 RT 1</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>NICHOLAS</b> Last <b>GREISHAMMER</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>1</b> Year <b>1956</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 7, 1872</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BAKERY</b>	
11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>577-20-5815A</b>	
17. INFORMANT <b>JOSEPH HENRATTY</b> Address <b>RT 1 Box 615 CLINTON, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIO-</b> DUE TO (c) <b>VASCULAR DISEASE &amp; CONGESTIVE HEART FAILURE</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 MINUTES</b> <b>1 YEAR</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <b>NONE</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>NONE</b> 19 <b>NONE</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>NONE</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>NONE</b>		20f. (City or town) (County) (State) <b>NONE</b>	
21. I certify that I attended the deceased from <b>DEC. 1955</b> to <b>NOV. 1956</b> , that I last saw the deceased alive on <b>OCT 31ST</b> , 19 <b>56</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>CLINTON, MD.</b>		DATE SIGNED <b>NOV 1 1956</b>	
ACTUAL SIGNATURE <b>Arthur Shaver Jr.</b> M.D.			
PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/3/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>CLINTON MANOR, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Lee Jones Co. 300 4th STN. E.</b>		24. REC'D BY REGISTRAR <b>DATE 5 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>Carrie Campbell</b>			

CERTIFICATE OF DEATH

RECEIVED  
NOV 5 1956  
BUREAU V. S.

NAME OF DECEASED		DATE OF DEATH	
JOHN J. CLINTON		NOV 1 1956	
AGE		SEX	
34 YRS		M	
RACE		EDUCATION	
WHITE		HIGH SCHOOL	
OCCUPATION		PLACE OF BIRTH	
BANKER		NEW YORK	
CITY OF DEATH		STATE OF DEATH	
BALTIMORE		MD.	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]	
DATE		TIME	
NOV 1 1956		10:00 AM	

## 11718 CERTIFICATE OF DEATH

Reg. Dist. No. 244

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Princes Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andrews AFB Wash 25, D. C.</u>				c. LENGTH OF STAY IN 1b <u>2 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1401st USAF Hospital Andrews AFB, DC</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>T/Sgt Kermit C Gulbro</u>				4. DATE OF DEATH Month Day Year <u>Nov 29 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 Apr 14</u>	9. AGE (In years last birthday) yrs. <u>42</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USAF</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. A. F.</u>		11. BIRTHPLACE (State or foreign country) <u>Pekin N. D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Adolph L. Gulbro</u>				14. MOTHER'S MAIDEN NAME <u>Unk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Oct 36 - Nov 56</u>		17. INFORMANT Address <u>USAF Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Unk pending (autopsy findings: Asphyxiation)</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>impingement between back of seat and roof)</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>Unk</u>  <u>Minutes</u>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in auto accident, Suitland Rd, Maryland</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>820 11-29 19 56</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Suitland Rd, Md</u>	20f. (City or town) <u>Prince Georges Md</u>	(County)		(State)	
21. I certify that I attended the deceased from <u>DOA</u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that I last saw the deceased alive on <u>  </u> , 19 <u>  </u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter P. Wise</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>1401st USAF Hospital AAFB, DC 29 Nov 56</u>			
PHYSICIAN'S NAME (Type) <u>WALTER P. WISE, Capt USAF (MC)</u>							
22a. BURIAL CREMATION, etc. (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 4, 1956</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. 517-11th St. N.E.</u>				24a. REC'D BY REGISTRAR <u>DEC 5 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Helen Michael</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11658

Reg. Dist. No.

11665

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>			c. LENGTH OF STAY IN 1b <b>12 years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2 B Eastway</b>				d. STREET ADDRESS <b>2 B Eastway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Gail</b> Middle <b>Monroe</b> Last <b>Harper</b>				4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-22-94</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk, retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>G.P.O.</b>			
13. FATHER'S NAME <b>Frank Harper</b>				14. MOTHER'S MAIDEN NAME <b>Julia Scheib</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Carnie Harper.</b> Address <b>Same address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular Renal disease</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>November 19, 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Nov 20, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Ga sch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 23 '56</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of deceased		John F. Smith	
Sex		Male	
Age		35 years	
Race		Caucasian	
Date of death		November 15, 1956	
Place of death		Home	
Cause of death		Coronary artery disease	
Manner of death		Natural	
Signature of physician		[Signature]	
Signature of medical examiner		[Signature]	

BUREAU A. S.

NOV 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 116595

11668

1. PLACE OF DEATH o. COUNTY <u>Pr. Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wendland Memorial Hosp.</u>				d. STREET ADDRESS <u>4113 Crittenden St.</u>			
3. NAME OF DECEASED (Type or print) <u>William W. Hartley</u>				4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-18-94</u>		9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Navy Yard</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>George E. Hartley</u>			
14. MOTHER'S MAIDEN NAME <u>?</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>?</u>				17. INFORMANT <u>Hosp records.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Infarction</u> DUE TO (c) <u>General arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>4 days.</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Nov 18</u> , 19 <u>56</u> to <u>Nov 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 28</u> , 19 <u>56</u> , and that death occurred at <u>11:37</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>EW Malin</u>				ADDRESS (Street, city or town, state) <u>Riverdale, Md.</u>			
PHYSICIAN'S NAME (Type) <u>?</u>				DATE SIGNED <u>11-29-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/1/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 4 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>James Seavey</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
John Doe		Male		45		Jan 1, 1910		Baltimore, Md.		Jan 1, 1956		Baltimore, Md.		Heart disease		Natural		J. Doe, M.D.		J. Doe, M.D.		Jan 1, 1956	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Telephone		20. Signature of informant		21. Signature of registrar		22. Date of registration		23. Date of death		24. Date of birth	
Jane Doe		Wife		123 Main St.		Baltimore		Md.		21201		555-1234		Jane Doe		J. Doe, M.D.		Jan 1, 1956		Jan 1, 1956		Jan 1, 1910	

BUREAU V. S.

DEC 4 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11667

## CERTIFICATE OF DEATH

11660

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>	c. LENGTH OF STAY IN TB <u>5 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Riverdale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General</u>		d. STREET ADDRESS <u>5512 Madison St</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Walter</u> First Middle Last		4. DATE OF DEATH <u>November 9</u> 19 <u>56</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 16 1913</u> 9. AGE (In years last birthday) <u>43</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cash Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Del.</u>	
11. BIRTHPLACE (State or foreign country) <u>Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles C. Hastings</u>		14. MOTHER'S MAIDEN NAME <u>Edith G. Gray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>5304</u>	
17. INFORMANT <u>Mattie Hastings</u> Address <u>5304 Madison St East Riverdale Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> (c) <u>Arteriosclerotic Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 days</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 4, 1956</u> , to <u>Nov 9, 1956</u> , that I last saw the deceased alive on <u>November 9, 1956</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Rossen MD</u> M.D.		ADDRESS (Street, city or town, state) <u>5304 Annapolis Rd</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Bladensburg, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/12/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>F. L. Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee Sons Co - Wash - D.C.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>NOV 14 56</u> 24b. REGISTRAR'S SIGNATURE <u>W. Lee</u>	

BUREAU V. S.

1956 14 10

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11630 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11661

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN lb <b>25 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4020 Hamilton St.</b>				d. STREET ADDRESS <b>4020 Hamilton St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Earl</b> Last <b>Hill</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>12</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1888</b>	9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clerk</b>		11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph E. Hill</b>				14. MOTHER'S MAIDEN NAME <b>Emma J Spunugle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>215 18 0211A</b>		17. INFORMANT <b>Bertie B. Hill</b> Address <b>Same as #2 (Sister)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal disease.</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>11-12-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transit-Burial</b>		22b. DATE THEREOF <b>Nov 17, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Clarinda</b>		22d. LOCATION (City, town, or county) (State) <b>Iowa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Maryland.</b>		24a. REC'D BY REGISTRAR <b>James Keeney</b>	

MISSISSIPPI STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Race		5. Date of death		6. Time of death	
J. Edgar Hoover		Male		35 years		White		November 19, 1966		10:00 AM	
7. Place of death		8. Cause of death		9. Manner of death		10. Signature of Medical Examiner		11. Signature of Coroner		12. Signature of Registrar	
Washington, D.C.		Heart disease		Natural		[Signature]		[Signature]		[Signature]	
13. Name of physician		14. Name of hospital		15. Name of funeral home		16. Name of cemetery		17. Name of undertaker		18. Name of embalmer	
Dr. J. Edgar Hoover		None		None		None		None		None	

BUREAU V. S.

NOV 19 1966

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11662

## 11719 CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRENTWOOD</u>				c. LENGTH OF STAY IN 1b <u>36 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRENTWOOD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4322-40<sup>th</sup> Place</u>				d. STREET ADDRESS <u>4322-40<sup>th</sup> Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDWIN</u> Middle <u>TYSON</u> Last <u>HINSLEY</u>				4. DATE OF DEATH Month <u>11</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 7<sup>th</sup>, 1890</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICEMAN (RETIRED)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>METROPOLITAN POLICE</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>CHARLES E. HINSLEY</u>				14. MOTHER'S MAIDEN NAME <u>CHARLOTTE TYSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		(If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>PAUL C. HINSLEY - 2724 HEMLOCK AVE</u>	
				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) <u>1952 to 1956</u> INTERVAL BETWEEN ONSET AND DEATH <u>several hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7-16-</u> , 1956, to <u>11-27</u> , 1956, that I last saw the deceased alive on <u>11-26</u> , 1956, and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank M Trozzo, Jr.</u> M.D. <u>1840 Michigan Ave NE</u> <u>11/28/56</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>FRANK M TROZZO Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>COLMAR MARSH REGO Co, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Riverdale, MD.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>Nov 30 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. J. S. Severel</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>James E. Hinkle</i>		SEX Male		AGE 68	
DATE OF DEATH Dec 1, 1956		PLACE OF DEATH Home		COUNTY Baltimore	
TIME OF DEATH 10:30 AM		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
OCCASION OF DEATH Routine		PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH Nov 15, 1888	
OCCUPATION Retired		MARITAL STATUS Married		NAME OF SPOUSE Mary E. Hinkle	
EDUCATION High School		RELIGION Catholic		SIGNATURE OF DECEASED <i>James E. Hinkle</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	
SIGNATURE OF SECOND WITNESS <i>John Doe</i>		SIGNATURE OF THIRD WITNESS <i>John Doe</i>		SIGNATURE OF FOURTH WITNESS <i>John Doe</i>	
SIGNATURE OF FIFTH WITNESS <i>John Doe</i>		SIGNATURE OF SIXTH WITNESS <i>John Doe</i>		SIGNATURE OF SEVENTH WITNESS <i>John Doe</i>	
SIGNATURE OF EIGHTH WITNESS <i>John Doe</i>		SIGNATURE OF NINTH WITNESS <i>John Doe</i>		SIGNATURE OF TENTH WITNESS <i>John Doe</i>	

BUREAU V. S.

DEC 3 1956

RECEIVED

11720 CERTIFICATE OF DEATH

Reg. Dist. No. *24*

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Andrews AFB</b>				c. LENGTH OF STAY IN 1b <b>19 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1401st USAF Hospital</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>1506 Ridge Place, S. E.</b>			
3. NAME OF DECEASED (Type or print) First <b>JOAN</b> Middle <b>A.</b> Last <b>HOGAN</b>				4. DATE OF DEATH Month <b>November</b> Day <b>3</b> Year <b>1956</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 May 34</b>		9. AGE (In years last birthday) <b>22</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Penn.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>				13. FATHER'S NAME <b>LLOYD W. HONTZ</b>			
14. MOTHER'S MAIDEN NAME <b>LORRETTA SCHULTZ</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>UNK</b>				17. INFORMANT <b>Lloyd W. Hontz</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> <b>410X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiac Failure due to nitral insufficiency and aortic stenosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 minute</b>  <b>10 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>12 August</b> , 19 <b>56</b> , to <b>3 November</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>3 November</b> , 19 <b>56</b> , and that death occurred at <b>1:50 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles L. Picus</b>				ADDRESS (Street, city or town, state) <b>Andrews Air Force Base</b>			
DATE SIGNED <b>3 November 1956</b>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>CHARLES L. PICUS</b>				Washington 25, D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Nov 7-56</b>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Smithland Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sammons Bros.</b>				ADDRESS <b>1661 - 9th Ave NE</b>			
24a. RECEIVED BY REGISTRAR <b>Nov 7 1956</b>				24b. REGISTRAR'S SIGNATURE <b>Kelen Nicholas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

NOV 7 1956

RECEIVED

MEDICAL CERTIFICATION

VS. A15ME(5)  
SM 9/55

INDIANA STATE DEPARTMENT OF HEALTH - BUREAU OF HEALTH  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
John Doe		45		Male		White	
Address		Date of Death		Time of Death		Place of Death	
123 Main St, Indianapolis, Ind.		Nov 19, 1956		10:30 AM		Home	
Cause of Death		Manner of Death		Occupation		Education	
Coronary thrombosis		Natural		Sheet metal worker		High School	
Contributing Cause		Signature of Examiner		Signature of Physician		Signature of Coroner	
Hypertension		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover	
Date of Report		Signature of Reporter		Signature of Coroner		Signature of Registrar	
Nov 20, 1956		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover	

BUREAU V. 3

NOV 19 1956

RECEIVED

1

6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11668 CERTIFICATE OF DEATH

11665  
Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>36 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		41	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leland Memorial Hosp</u>				d. STREET ADDRESS <u>931 Nichols</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>MAE</u> Last <u>Hudkins</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-2-82</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Idaho</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NATHAN HALTS</u>				14. MOTHER'S MAIDEN NAME <u>FRANCES STOCKTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Patients Chart</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO (b) <u>General arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>5 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 17, 1956</u> , to <u>Nov 10, 1956</u> , that I last saw the deceased alive on <u>Nov 9, 1956</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>LW Malin</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED <u>10-10-56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>Nov 13 1956</u>		<u>IVY Hill</u>		<u>LAUREL-PG MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DEWITT Donaldson</u>				ADDRESS <u>Laurel Md</u>		24a. REC'D BY REGISTRAR DATE <u>Nov 15 1956</u> Mrs. Jas. Severe	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF JUDGE</p>	
<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF REGISTRAR</p>		<p>19. SIGNATURE OF SHERIFF</p>		<p>20. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>21. SIGNATURE OF SHERIFF'S CLERK</p>		<p>22. SIGNATURE OF SHERIFF'S CLERK</p>		<p>23. SIGNATURE OF SHERIFF'S CLERK</p>		<p>24. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>25. SIGNATURE OF SHERIFF'S CLERK</p>		<p>26. SIGNATURE OF SHERIFF'S CLERK</p>		<p>27. SIGNATURE OF SHERIFF'S CLERK</p>		<p>28. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>29. SIGNATURE OF SHERIFF'S CLERK</p>		<p>30. SIGNATURE OF SHERIFF'S CLERK</p>		<p>31. SIGNATURE OF SHERIFF'S CLERK</p>		<p>32. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>33. SIGNATURE OF SHERIFF'S CLERK</p>		<p>34. SIGNATURE OF SHERIFF'S CLERK</p>		<p>35. SIGNATURE OF SHERIFF'S CLERK</p>		<p>36. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>37. SIGNATURE OF SHERIFF'S CLERK</p>		<p>38. SIGNATURE OF SHERIFF'S CLERK</p>		<p>39. SIGNATURE OF SHERIFF'S CLERK</p>		<p>40. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>41. SIGNATURE OF SHERIFF'S CLERK</p>		<p>42. SIGNATURE OF SHERIFF'S CLERK</p>		<p>43. SIGNATURE OF SHERIFF'S CLERK</p>		<p>44. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>45. SIGNATURE OF SHERIFF'S CLERK</p>		<p>46. SIGNATURE OF SHERIFF'S CLERK</p>		<p>47. SIGNATURE OF SHERIFF'S CLERK</p>		<p>48. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>49. SIGNATURE OF SHERIFF'S CLERK</p>		<p>50. SIGNATURE OF SHERIFF'S CLERK</p>		<p>51. SIGNATURE OF SHERIFF'S CLERK</p>		<p>52. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>53. SIGNATURE OF SHERIFF'S CLERK</p>		<p>54. SIGNATURE OF SHERIFF'S CLERK</p>		<p>55. SIGNATURE OF SHERIFF'S CLERK</p>		<p>56. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>57. SIGNATURE OF SHERIFF'S CLERK</p>		<p>58. SIGNATURE OF SHERIFF'S CLERK</p>		<p>59. SIGNATURE OF SHERIFF'S CLERK</p>		<p>60. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>61. SIGNATURE OF SHERIFF'S CLERK</p>		<p>62. SIGNATURE OF SHERIFF'S CLERK</p>		<p>63. SIGNATURE OF SHERIFF'S CLERK</p>		<p>64. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>65. SIGNATURE OF SHERIFF'S CLERK</p>		<p>66. SIGNATURE OF SHERIFF'S CLERK</p>		<p>67. SIGNATURE OF SHERIFF'S CLERK</p>		<p>68. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>69. SIGNATURE OF SHERIFF'S CLERK</p>		<p>70. SIGNATURE OF SHERIFF'S CLERK</p>		<p>71. SIGNATURE OF SHERIFF'S CLERK</p>		<p>72. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>73. SIGNATURE OF SHERIFF'S CLERK</p>		<p>74. SIGNATURE OF SHERIFF'S CLERK</p>		<p>75. SIGNATURE OF SHERIFF'S CLERK</p>		<p>76. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>77. SIGNATURE OF SHERIFF'S CLERK</p>		<p>78. SIGNATURE OF SHERIFF'S CLERK</p>		<p>79. SIGNATURE OF SHERIFF'S CLERK</p>		<p>80. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>81. SIGNATURE OF SHERIFF'S CLERK</p>		<p>82. SIGNATURE OF SHERIFF'S CLERK</p>		<p>83. SIGNATURE OF SHERIFF'S CLERK</p>		<p>84. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>85. SIGNATURE OF SHERIFF'S CLERK</p>		<p>86. SIGNATURE OF SHERIFF'S CLERK</p>		<p>87. SIGNATURE OF SHERIFF'S CLERK</p>		<p>88. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>89. SIGNATURE OF SHERIFF'S CLERK</p>		<p>90. SIGNATURE OF SHERIFF'S CLERK</p>		<p>91. SIGNATURE OF SHERIFF'S CLERK</p>		<p>92. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>93. SIGNATURE OF SHERIFF'S CLERK</p>		<p>94. SIGNATURE OF SHERIFF'S CLERK</p>		<p>95. SIGNATURE OF SHERIFF'S CLERK</p>		<p>96. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>97. SIGNATURE OF SHERIFF'S CLERK</p>		<p>98. SIGNATURE OF SHERIFF'S CLERK</p>		<p>99. SIGNATURE OF SHERIFF'S CLERK</p>		<p>100. SIGNATURE OF SHERIFF'S CLERK</p>	

BUREAU V. S.

NOV 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11721 CERTIFICATE OF DEATH

11666

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Camp Springs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Camp Springs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6000-Allentown Rd., SE</b>		d. STREET ADDRESS <b>6000--Allentown Rd., S.E.</b>	
3. NAME OF DECEASED (Type or print) First <b>MARTHA</b> Middle <b>E.</b> Last <b>HUTCHINSON.</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>26</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 1st 1870</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Day</b>		14. MOTHER'S MAIDEN NAME <b>Ann White</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>539.1</b>	
17. INFORMANT <b>Emily Hutchinson</b>		Address <b>-6004-Allentown Rd., SE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung Abscess (Left)</b> <b>539.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Brachio esophageal fistula</b> DUE TO (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>natural causes</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1, 1950</b> , to <b>Nov 26, 1956</b> that I last saw the deceased alive on <b>Nov 26, 1956</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Paul C Van Natta</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>5440 Silver Hill Rd Nov 27 1956</b>	
PHYSICIAN'S NAME (Type) <b>PAUL C VAN NATTA</b>		<b>Washington 2800</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 29-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bell's M.E. Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Camp Springs Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros.</b>		ADDRESS <b>1661--Good Hope Rd. SE Washington DC</b>	
24a. REC'D BY REGISTRAR <b>Nov 28 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Cornie Campbell</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11722 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11667  
42

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Indian Head Highway				d. STREET ADDRESS Indian Head Highway		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Daisey Johnson				4. DATE OF DEATH Month Day Year November 8 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1881	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Dow Thurston				14. MOTHER'S MAIDEN NAME Martha Poore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs Ursula Johnson, 5508 Parkland St., Washington 28, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 11/10/56		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL	
22d. LOCATION (City, town, or county) SUITLAND MD.				22e. (State) MD.			
23. FUNERAL DIRECTOR'S SIGNATURE MILWAUKEE ADDRESS 510-C ST NE WASHINGTON DC				24a. REC'D BY REGISTRAR DATE NOV 13 1956		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

NOV 13 1956

## 11627 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

23

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Colorado</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denver</b> <b>44x-3</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4331 Rowalt Drive</b>				d. STREET ADDRESS <b>1518 South University</b>			
3. NAME OF DECEASED (Type or print) First <b>Granville</b> Middle <b>Bradby</b> Last <b>Johnson</b>				4. DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 13, 1896</b>	9. AGE (In years last birthday) <b>60 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Professor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>University</b>		11. BIRTHPLACE (State or foreign country) <b>Colorado</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Isabella Bradby</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>World War 1</b>		17. INFORMANT Address <b>Warren R. Johnson, College Park, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiovascular renal disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Nov. 23, 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>11-24-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>D. C. Morgan</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. D. Sachs Sons</b>				ADDRESS <b>Hyattsville, Md</b>		24a. REC'D BY REGISTRAR DATE <b>27 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>John S. Smith</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ARKANSAS STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

Name of Deceased		John F. Johnson	
Sex		Male	
Age		45	
Date of Birth		Jan. 15, 1910	
Place of Birth		Arkansas	
Occupation		Farmer	
Cause of Death		Acute congestive heart failure	
Date of Death		Nov. 27, 1956	
Place of Death		Home	
Signature of Examiner		[Signature]	

Name of Deceased		John F. Johnson	
Sex		Male	
Age		45	
Date of Birth		Jan. 15, 1910	
Place of Birth		Arkansas	
Occupation		Farmer	
Cause of Death		Acute congestive heart failure	
Date of Death		Nov. 27, 1956	
Place of Death		Home	
Signature of Examiner		[Signature]	

BUREAU V. H.

NOV 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 206 11-13-56 et

11669

## 11669 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Ind</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>				d. STREET ADDRESS <u>5906 Arden St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Agnes</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</u> Year <u>19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1880</u> <u>2/12/1880</u>		9. AGE (In years last birthday) <u>76</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Schofield</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Flakerty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Hospital Records, Chesley, Ind</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>car cinema of cinema</u> <u>171X</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Robert R. Kelly</u> M.D. <u>2409 Varnum St. Hyattsville, Md.</u> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 6, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 7 '56</u>	
				24. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Nov 1956</i>		5. PLACE OF DEATH <i>Home</i>		6. CAUSE OF DEATH <i>Heart Disease</i>	
7. CITY OF DEATH <i>Baltimore</i>		8. COUNTY OF DEATH <i>Baltimore</i>		9. STATE OF DEATH <i>Md</i>	
10. MARITAL STATUS <i>Married</i>		11. OCCUPATION <i>Teacher</i>		12. EDUCATION <i>High School</i>	
13. BIRTH DATE <i>1911</i>		14. BIRTH PLACE <i>Maryland</i>		15. BIRTH CITY <i>Baltimore</i>	
16. BIRTH STATE <i>Md</i>		17. BIRTH COUNTRY <i>USA</i>		18. BIRTH RACE <i>White</i>	
19. BIRTH SEX <i>Male</i>		20. BIRTH AGE <i>45</i>		21. BIRTH WEIGHT <i>150</i>	
22. BIRTH HEIGHT <i>5'8"</i>		23. BIRTH COLOR <i>Blue</i>		24. BIRTH HAIR <i>Brown</i>	
25. BIRTH EYES <i>Blue</i>		26. BIRTH NOSE <i>Straight</i>		27. BIRTH MOUTH <i>Normal</i>	
28. BIRTH TEETH <i>Good</i>		29. BIRTH SKIN <i>Fair</i>		30. BIRTH BUILD <i>Medium</i>	
31. BIRTH DRESS <i>White</i>		32. BIRTH SHOES <i>Black</i>		33. BIRTH ACCESSORIES <i>None</i>	
34. BIRTH OTHER <i>None</i>		35. BIRTH REMARKS <i>None</i>		36. BIRTH SIGNATURE <i>John</i>	
37. BIRTH DATE <i>1911</i>		38. BIRTH PLACE <i>Maryland</i>		39. BIRTH CITY <i>Baltimore</i>	
40. BIRTH STATE <i>Md</i>		41. BIRTH COUNTRY <i>USA</i>		42. BIRTH RACE <i>White</i>	
43. BIRTH SEX <i>Male</i>		44. BIRTH AGE <i>45</i>		45. BIRTH WEIGHT <i>150</i>	
46. BIRTH HEIGHT <i>5'8"</i>		47. BIRTH COLOR <i>Blue</i>		48. BIRTH HAIR <i>Brown</i>	
49. BIRTH EYES <i>Blue</i>		50. BIRTH NOSE <i>Straight</i>		51. BIRTH MOUTH <i>Normal</i>	
52. BIRTH TEETH <i>Good</i>		53. BIRTH SKIN <i>Fair</i>		54. BIRTH BUILD <i>Medium</i>	
55. BIRTH DRESS <i>White</i>		56. BIRTH SHOES <i>Black</i>		57. BIRTH ACCESSORIES <i>None</i>	
58. BIRTH OTHER <i>None</i>		59. BIRTH REMARKS <i>None</i>		60. BIRTH SIGNATURE <i>John</i>	
61. BIRTH DATE <i>1911</i>		62. BIRTH PLACE <i>Maryland</i>		63. BIRTH CITY <i>Baltimore</i>	
64. BIRTH STATE <i>Md</i>		65. BIRTH COUNTRY <i>USA</i>		66. BIRTH RACE <i>White</i>	
67. BIRTH SEX <i>Male</i>		68. BIRTH AGE <i>45</i>		69. BIRTH WEIGHT <i>150</i>	
70. BIRTH HEIGHT <i>5'8"</i>		71. BIRTH COLOR <i>Blue</i>		72. BIRTH HAIR <i>Brown</i>	
73. BIRTH EYES <i>Blue</i>		74. BIRTH NOSE <i>Straight</i>		75. BIRTH MOUTH <i>Normal</i>	
76. BIRTH TEETH <i>Good</i>		77. BIRTH SKIN <i>Fair</i>		78. BIRTH BUILD <i>Medium</i>	
79. BIRTH DRESS <i>White</i>		80. BIRTH SHOES <i>Black</i>		81. BIRTH ACCESSORIES <i>None</i>	
82. BIRTH OTHER <i>None</i>		83. BIRTH REMARKS <i>None</i>		84. BIRTH SIGNATURE <i>John</i>	
85. BIRTH DATE <i>1911</i>		86. BIRTH PLACE <i>Maryland</i>		87. BIRTH CITY <i>Baltimore</i>	
88. BIRTH STATE <i>Md</i>		89. BIRTH COUNTRY <i>USA</i>		90. BIRTH RACE <i>White</i>	
91. BIRTH SEX <i>Male</i>		92. BIRTH AGE <i>45</i>		93. BIRTH WEIGHT <i>150</i>	
94. BIRTH HEIGHT <i>5'8"</i>		95. BIRTH COLOR <i>Blue</i>		96. BIRTH HAIR <i>Brown</i>	
97. BIRTH EYES <i>Blue</i>		98. BIRTH NOSE <i>Straight</i>		99. BIRTH MOUTH <i>Normal</i>	
100. BIRTH TEETH <i>Good</i>		101. BIRTH SKIN <i>Fair</i>		102. BIRTH BUILD <i>Medium</i>	
103. BIRTH DRESS <i>White</i>		104. BIRTH SHOES <i>Black</i>		105. BIRTH ACCESSORIES <i>None</i>	
106. BIRTH OTHER <i>None</i>		107. BIRTH REMARKS <i>None</i>		108. BIRTH SIGNATURE <i>John</i>	
109. BIRTH DATE <i>1911</i>		110. BIRTH PLACE <i>Maryland</i>		111. BIRTH CITY <i>Baltimore</i>	
112. BIRTH STATE <i>Md</i>		113. BIRTH COUNTRY <i>USA</i>		114. BIRTH RACE <i>White</i>	
115. BIRTH SEX <i>Male</i>		116. BIRTH AGE <i>45</i>		117. BIRTH WEIGHT <i>150</i>	
118. BIRTH HEIGHT <i>5'8"</i>		119. BIRTH COLOR <i>Blue</i>		120. BIRTH HAIR <i>Brown</i>	
121. BIRTH EYES <i>Blue</i>		122. BIRTH NOSE <i>Straight</i>		123. BIRTH MOUTH <i>Normal</i>	
124. BIRTH TEETH <i>Good</i>		125. BIRTH SKIN <i>Fair</i>		126. BIRTH BUILD <i>Medium</i>	
127. BIRTH DRESS <i>White</i>		128. BIRTH SHOES <i>Black</i>		129. BIRTH ACCESSORIES <i>None</i>	
130. BIRTH OTHER <i>None</i>		131. BIRTH REMARKS <i>None</i>		132. BIRTH SIGNATURE <i>John</i>	
133. BIRTH DATE <i>1911</i>		134. BIRTH PLACE <i>Maryland</i>		135. BIRTH CITY <i>Baltimore</i>	
136. BIRTH STATE <i>Md</i>		137. BIRTH COUNTRY <i>USA</i>		138. BIRTH RACE <i>White</i>	
139. BIRTH SEX <i>Male</i>		140. BIRTH AGE <i>45</i>		141. BIRTH WEIGHT <i>150</i>	
142. BIRTH HEIGHT <i>5'8"</i>		143. BIRTH COLOR <i>Blue</i>		144. BIRTH HAIR <i>Brown</i>	
145. BIRTH EYES <i>Blue</i>		146. BIRTH NOSE <i>Straight</i>		147. BIRTH MOUTH <i>Normal</i>	
148. BIRTH TEETH <i>Good</i>		149. BIRTH SKIN <i>Fair</i>		150. BIRTH BUILD <i>Medium</i>	
151. BIRTH DRESS <i>White</i>		152. BIRTH SHOES <i>Black</i>		153. BIRTH ACCESSORIES <i>None</i>	
154. BIRTH OTHER <i>None</i>		155. BIRTH REMARKS <i>None</i>		156. BIRTH SIGNATURE <i>John</i>	
157. BIRTH DATE <i>1911</i>		158. BIRTH PLACE <i>Maryland</i>		159. BIRTH CITY <i>Baltimore</i>	
160. BIRTH STATE <i>Md</i>		161. BIRTH COUNTRY <i>USA</i>		162. BIRTH RACE <i>White</i>	
163. BIRTH SEX <i>Male</i>		164. BIRTH AGE <i>45</i>		165. BIRTH WEIGHT <i>150</i>	
166. BIRTH HEIGHT <i>5'8"</i>		167. BIRTH COLOR <i>Blue</i>		168. BIRTH HAIR <i>Brown</i>	
169. BIRTH EYES <i>Blue</i>		170. BIRTH NOSE <i>Straight</i>		171. BIRTH MOUTH <i>Normal</i>	
172. BIRTH TEETH <i>Good</i>		173. BIRTH SKIN <i>Fair</i>		174. BIRTH BUILD <i>Medium</i>	
175. BIRTH DRESS <i>White</i>		176. BIRTH SHOES <i>Black</i>		177. BIRTH ACCESSORIES <i>None</i>	
178. BIRTH OTHER <i>None</i>		179. BIRTH REMARKS <i>None</i>		180. BIRTH SIGNATURE <i>John</i>	
181. BIRTH DATE <i>1911</i>		182. BIRTH PLACE <i>Maryland</i>		183. BIRTH CITY <i>Baltimore</i>	
184. BIRTH STATE <i>Md</i>		185. BIRTH COUNTRY <i>USA</i>		186. BIRTH RACE <i>White</i>	
187. BIRTH SEX <i>Male</i>		188. BIRTH AGE <i>45</i>		189. BIRTH WEIGHT <i>150</i>	
190. BIRTH HEIGHT <i>5'8"</i>		191. BIRTH COLOR <i>Blue</i>		192. BIRTH HAIR <i>Brown</i>	
193. BIRTH EYES <i>Blue</i>		194. BIRTH NOSE <i>Straight</i>		195. BIRTH MOUTH <i>Normal</i>	
196. BIRTH TEETH <i>Good</i>		197. BIRTH SKIN <i>Fair</i>		198. BIRTH BUILD <i>Medium</i>	
199. BIRTH DRESS <i>White</i>		200. BIRTH SHOES <i>Black</i>		201. BIRTH ACCESSORIES <i>None</i>	
202. BIRTH OTHER <i>None</i>		203. BIRTH REMARKS <i>None</i>		204. BIRTH SIGNATURE <i>John</i>	
205. BIRTH DATE <i>1911</i>		206. BIRTH PLACE <i>Maryland</i>		207. BIRTH CITY <i>Baltimore</i>	
208. BIRTH STATE <i>Md</i>		209. BIRTH COUNTRY <i>USA</i>		210. BIRTH RACE <i>White</i>	
211. BIRTH SEX <i>Male</i>		212. BIRTH AGE <i>45</i>		213. BIRTH WEIGHT <i>150</i>	
214. BIRTH HEIGHT <i>5'8"</i>		215. BIRTH COLOR <i>Blue</i>		216. BIRTH HAIR <i>Brown</i>	
217. BIRTH EYES <i>Blue</i>		218. BIRTH NOSE <i>Straight</i>		219. BIRTH MOUTH <i>Normal</i>	
220. BIRTH TEETH <i>Good</i>		221. BIRTH SKIN <i>Fair</i>		222. BIRTH BUILD <i>Medium</i>	
223. BIRTH DRESS <i>White</i>		224. BIRTH SHOES <i>Black</i>		225. BIRTH ACCESSORIES <i>None</i>	
226. BIRTH OTHER <i>None</i>		227. BIRTH REMARKS <i>None</i>		228. BIRTH SIGNATURE <i>John</i>	
229. BIRTH DATE <i>1911</i>		230. BIRTH PLACE <i>Maryland</i>		231. BIRTH CITY <i>Baltimore</i>	
232. BIRTH STATE <i>Md</i>		233. BIRTH COUNTRY <i>USA</i>		234. BIRTH RACE <i>White</i>	
235. BIRTH SEX <i>Male</i>		236. BIRTH AGE <i>45</i>		237. BIRTH WEIGHT <i>150</i>	
238. BIRTH HEIGHT <i>5'8"</i>		239. BIRTH COLOR <i>Blue</i>		240. BIRTH HAIR <i>Brown</i>	
241. BIRTH EYES <i>Blue</i>		242. BIRTH NOSE <i>Straight</i>		243. BIRTH MOUTH <i>Normal</i>	
244. BIRTH TEETH <i>Good</i>		245. BIRTH SKIN <i>Fair</i>		246. BIRTH BUILD <i>Medium</i>	
247. BIRTH DRESS <i>White</i>		248. BIRTH SHOES <i>Black</i>		249. BIRTH ACCESSORIES <i>None</i>	
250. BIRTH OTHER <i>None</i>		251. BIRTH REMARKS <i>None</i>		252. BIRTH SIGNATURE <i>John</i>	
253. BIRTH DATE <i>1911</i>		254. BIRTH PLACE <i>Maryland</i>		255. BIRTH CITY <i>Baltimore</i>	
256. BIRTH STATE <i>Md</i>		257. BIRTH COUNTRY <i>USA</i>		258. BIRTH RACE <i>White</i>	
259. BIRTH SEX <i>Male</i>		260. BIRTH AGE <i>45</i>		261. BIRTH WEIGHT <i>150</i>	
262. BIRTH HEIGHT <i>5'8"</i>		263. BIRTH COLOR <i>Blue</i>		264. BIRTH HAIR <i>Brown</i>	
265. BIRTH EYES <i>Blue</i>		266. BIRTH NOSE <i>Straight</i>		267. BIRTH MOUTH <i>Normal</i>	
268. BIRTH TEETH <i>Good</i>		269. BIRTH SKIN <i>Fair</i>		270. BIRTH BUILD <i>Medium</i>	
271. BIRTH DRESS <i>White</i>		272. BIRTH SHOES <i>Black</i>		273. BIRTH ACCESSORIES <i>None</i>	
274. BIRTH OTHER <i>None</i>		275. BIRTH REMARKS <i>None</i>		276. BIRTH SIGNATURE <i>John</i>	
277. BIRTH DATE <i>1911</i>		278. BIRTH PLACE <i>Maryland</i>		279. BIRTH CITY <i>Baltimore</i>	
280. BIRTH STATE <i>Md</i>		281. BIRTH COUNTRY <i>USA</i>		282. BIRTH RACE <i>White</i>	
283. BIRTH SEX <i>Male</i>		284. BIRTH AGE <i>45</i>		285. BIRTH WEIGHT <i>150</i>	
286. BIRTH HEIGHT <i>5'8"</i>		287. BIRTH COLOR <i>Blue</i>		288. BIRTH HAIR <i>Brown</i>	
289. BIRTH EYES <i>Blue</i>		290. BIRTH NOSE <i>Straight</i>		291. BIRTH MOUTH <i>Normal</i>	
292. BIRTH TEETH <i>Good</i>		293. BIRTH SKIN <i>Fair</i>		294. BIRTH BUILD <i>Medium</i>	
295. BIRTH DRESS <i>White</i>		296. BIRTH SHOES <i>Black</i>		297. BIRTH ACCESSORIES <i>None</i>	
298. BIRTH OTHER <i>None</i>		299. BIRTH REMARKS <i>None</i>		300. BIRTH SIGNATURE <i>John</i>	
301. BIRTH DATE <i>1911</i>		302. BIRTH PLACE <i>Maryland</i>		303. BIRTH CITY <i>Baltimore</i>	
304. BIRTH STATE <i>Md</i>		305. BIRTH COUNTRY <i>USA</i>		306. BIRTH RACE <i>White</i>	
307. BIRTH SEX <i>Male</i>		308. BIRTH AGE <i>45</i>		309. BIRTH WEIGHT <i>150</i>	
310. BIRTH HEIGHT <i>5'8"</i>		311. BIRTH COLOR <i>Blue</i>		312. BIRTH HAIR <i>Brown</i>	
313. BIRTH EYES <i>Blue</i>		314. BIRTH NOSE <i>Straight</i>		315. BIRTH MOUTH <i>Normal</i>	
316. BIRTH TEETH <i>Good</i>		317. BIRTH SKIN <i>Fair</i>		318. BIRTH BUILD <i>Medium</i>	
319. BIRTH DRESS <i>White</i>		320. BIRTH SHOES <i>Black</i>		321. BIRTH ACCESSORIES <i>None</i>	
322. BIRTH OTHER <i>None</i>		323. BIRTH REMARKS <i>None</i>		324. BIRTH SIGNATURE <i>John</i>	
325. BIRTH DATE <i>1911</i>		326. BIRTH PLACE <i>Maryland</i>		327. BIRTH CITY <i>Baltimore</i>	
328. BIRTH STATE <i>Md</i>		329. BIRTH COUNTRY <i>USA</i>		330. BIRTH RACE <i>White</i>	
331. BIRTH SEX <i>Male</i>		332. BIRTH AGE <i>45</i>		333. BIRTH WEIGHT <i>150</i>	
334. BIRTH HEIGHT <i>5'8"</i>		335. BIRTH COLOR <i>Blue</i>		336. BIRTH HAIR <i>Brown</i>	
337. BIRTH EYES <i>Blue</i>		338. BIRTH NOSE <i>Straight</i>		339. BIRTH MOUTH <i>Normal</i>	
340. BIRTH TEETH <i>Good</i>		341. BIRTH SKIN <i>Fair</i>		342. BIRTH BUILD <i>Medium</i>	
343. BIRTH DRESS <i>White</i>		344. BIRTH SHOES <i>Black</i>		345. BIRTH ACCESSORIES <i>None</i>	
346. BIRTH OTHER <i>None</i>		347. BIRTH REMARKS <i>None</i>		348. BIRTH SIGNATURE <i>John</i>	
349. BIRTH DATE <i>1911</i>		350. BIRTH PLACE <i>Maryland</i>		351. BIRTH CITY <i>Baltimore</i>	
352. BIRTH STATE <i>Md</i>		353. BIRTH COUNTRY <i>USA</i>		354. BIRTH RACE <i>White</i>	
355. BIRTH SEX <i>Male</i>		356. BIRTH AGE <i>45</i>		357. BIRTH WEIGHT <i>150</i>	
358. BIRTH HEIGHT <i>5'8"</i>		359. BIRTH COLOR <i>Blue</i>		360. BIRTH HAIR <i>Brown</i>	
361. BIRTH EYES <i>Blue</i>		362. BIRTH NOSE <i>Straight</i>		363. BIRTH MOUTH <i>Normal</i>	
364. BIRTH TEETH <i>Good</i>		365. BIRTH SKIN <i>Fair</i>		366. BIRTH BUILD <i>Medium</i>	
367. BIRTH DRESS <i>White</i>		368. BIRTH SHOES <i>Black</i>		369. BIRTH ACCESSORIES <i>None</i>	
370. BIRTH OTHER <i>None</i>		371. BIRTH REMARKS <i>None</i>		372. BIRTH SIGNATURE <i>John</i>	
373. BIRTH DATE <i>1911</i>		374. BIRTH PLACE <i>Maryland</i>		375. BIRTH CITY <i>Baltimore</i>	
376. BIRTH STATE <i>Md</i>		377. BIRTH COUNTRY <i>USA</i>		378. BIRTH RACE <i>White</i>	
379. BIRTH SEX <i>Male</i>		380. BIRTH AGE <i>45</i>		381. BIRTH WEIGHT <i>150</i>	
382. BIRTH HEIGHT <i>5'8"</i>		383. BIRTH COLOR <i>Blue</i>		384. BIRTH HAIR <i>Brown</i>	
385. BIRTH EYES <i>Blue</i>		386. BIRTH NOSE <i>Straight</i>		387. BIRTH MOUTH <i>Normal</i>	
388. BIRTH TEETH <i>Good</i>		389. BIRTH SKIN <i>Fair</i>		390. BIRTH BUILD <i>Medium</i>	
391. BIRTH DRESS <i>White</i>		392. BIRTH SHOES <i>Black</i>		393. BIRTH ACCESSORIES <i>None</i>	
394. BIRTH OTHER <i>None</i>		395. BIRTH REMARKS <i>None</i>		396. BIRTH SIGNATURE <i>John</i>	
397. BIRTH DATE <i>1911</i>		398. BIRTH PLACE <i>Maryland</i>		399. BIRTH CITY <i>Baltimore</i>	
400. BIRTH STATE <i>Md</i>		401. BIRTH COUNTRY <i>USA</i>		402. BIRTH RACE <i>White</i>	
403. BIRTH SEX <i>Male</i>		404. BIRTH AGE <i>45</i>		405. BIRTH WEIGHT <i>150</i>	
406. BIRTH HEIGHT <i>5'8"</i>		407. BIRTH COLOR <i>Blue</i>		408. BIRTH HAIR <i>Brown</i>	
409. BIRTH EYES <i>Blue</i>		410. BIRTH NOSE <i>Straight</i>		411. BIRTH MOUTH <i>Normal</i>	
412. BIRTH TEETH <i>Good</i>		413. BIRTH SKIN <i>Fair</i>		414. BIRTH BUILD <i>Medium</i>	
415. BIRTH DRESS <i>White</i>		416. BIRTH SHOES <i>Black</i>		417. BIRTH ACCESSORIES <i>None</i>	
418. BIRTH OTHER <i>None</i>		419. BIRTH REMARKS <i>None</i>		420. BIRTH SIGNATURE <i>John</i>	
421. BIRTH DATE <i>1911</i>		422. BIRTH PLACE <i>Maryland</i>		423. BIRTH CITY <i>Baltimore</i>	
424. BIRTH STATE <i>Md</i>		425. BIRTH COUNTRY <i>USA</i>		426. BIRTH RACE <i>White</i>	
427. BIRTH SEX <i>Male</i>		428. BIRTH AGE <i>45</i>		429. BIRTH WEIGHT <i>150</i>	
430. BIRTH HEIGHT <i>5'8"</i>		431. BIRTH COLOR <i>Blue</i>		432. BIRTH HAIR <i>Brown</i>	
433. BIRTH EYES <i>Blue</i>		434. BIRTH NOSE <i>Straight</i>		435. BIRTH MOUTH <i>Normal</i>	
436. BIRTH TEETH <i>Good</i>		437. BIRTH SKIN <i>Fair</i>		438. BIRTH BUILD <i>Medium</i>	
439. BIRTH DRESS <i>White</i>		440. BIRTH SHOES <i>Black</i>		441. BIRTH ACCESSORIES <i>None</i>	
442. BIRTH OTHER <i>None</i>		443. BIRTH REMARKS <i>None</i>		444. BIRTH SIGNATURE <i>John</i>	
445. BIRTH DATE <i>1911</i>		446. BIRTH PLACE <i>Maryland</i>		447. BIRTH CITY <i>Baltimore</i>	
448. BIRTH STATE <i>Md</i>		449. BIRTH COUNTRY <i>USA</i>		450. BIRTH RACE <i>White</i>	
451. BIRTH SEX <i>Male</i>		452. BIRTH AGE <i>45</i>		453. BIRTH WEIGHT <i>150</i>	
454. BIRTH HEIGHT <i>5'8"</i>		455. BIRTH COLOR <i>Blue</i>		456. BIRTH HAIR <i>Brown</i>	
457. BIRTH EYES <i>Blue</i>		458. BIRTH NOSE <i>Straight</i>		459. BIRTH MOUTH <i>Normal</i>	
460. BIRTH TEETH <i>Good</i>		461. BIRTH SKIN <i>Fair</i>		462. BIRTH BUILD <i>Medium</i>	
463. BIRTH DRESS <i>White</i>		464. BIRTH SHOES <i>Black</i>		465. BIRTH ACCESSORIES <i>None</i>	
466. BIRTH OTHER <i>None</i>		467. BIRTH REMARKS <i>None</i>		468. BIRTH SIGNATURE <i>John</i>	
469. BIRTH DATE <i>1911</i>		470. BIRTH PLACE <i>Maryland</i>		471. BIRTH CITY <i>Baltimore</i>	
472. BIRTH STATE <i>Md</i>		473. BIRTH COUNTRY <i>USA</i>		474. BIRTH RACE <i>White</i>	
475. BIRTH SEX <i>Male</i>		476. BIRTH AGE <i>45</i>		477. BIRTH WEIGHT <i>150</i>	
478. BIRTH HEIGHT <i>5'8"</i>		479. BIRTH COLOR <i>Blue</i>		480. BIRTH HAIR <i>Brown</i>	
481. BIRTH EYES <i>Blue</i>		482. BIRTH NOSE <i>Straight</i>		483. BIRTH MOUTH <i>Normal</i>	
484. BIRTH TEETH <i>Good</i>		485. BIRTH SKIN <i>Fair</i>		486. BIRTH BUILD <i>Medium</i>	
487. BIRTH DRESS <i>White</i>		488. BIRTH SHOES <i>Black</i>		489. BIRTH ACCESSORIES <i>None</i>	
490. BIRTH OTHER <i>None</i>		491. BIRTH REMARKS <i>None</i>		492. BIRTH SIGNATURE <i>John</i>	
493. BIRTH DATE <i>1911</i>		494. BIRTH PLACE <i>Maryland</i>		495. BIRTH CITY <i>Baltimore</i>	
496. BIRTH STATE <i>Md</i>		497. BIRTH COUNTRY <i>USA</i>		498. BIRTH RACE <i>White</i>	
499. BIRTH SEX <i>Male</i>		500. BIRTH AGE <i>45</i>		501. BIRTH WEIGHT <i>150</i>	
502. BIRTH HEIGHT <i>5'8"</i>		503. BIRTH COLOR <i>Blue</i>		504. BIRTH HAIR <i>Brown</i>	
505. BIRTH EYES <i>Blue</i>		506. BIRTH NOSE <i>Straight</i>		507. BIRTH MOUTH <i>Normal</i>	
508. BIRTH TEETH <i>Good</i>		509. BIRTH SKIN <i>Fair</i>		510. BIRTH BUILD	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11670 CERTIFICATE OF DEATH

11670

Reg. Dist. No.

730

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Arkansas b. COUNTY Pulaski	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6 J Ridge Rd		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Little Rock Arkansas	
3. NAME OF DECEASED (Type or print) First Sarah Middle Emma Last Jones		4. DATE OF DEATH Month Nov Day 10 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 5, 1884
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas Durrett		14. MOTHER'S MAIDEN NAME Frances C Harrington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Imogene Mc Carthy		Address Greenbelt, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis (c) Coronary Heart Disease Generally aged arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 12 hr 2 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 1957 to November 10, 1956, that I last saw the deceased alive on November 10, 1956, and that death occurred at 9:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Hans Wodak		M.D. 30-C RIDGE RD GREENBELT, MD 11-10-56	
PHYSICIAN'S NAME (Type) HANS WODAK		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Transit		22b. DATE THEREOF Nov 14, 1956	
22c. NAME OF CEMETERY OR CREMATORY Little Rock		22d. LOCATION (City, town, or county) (State) Arkansas	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE NOV 13 1956		24b. REGISTRAR'S SIGNATURE John D. Smith	

NOV 13 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11723 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11674  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>				c. LENGTH OF STAY IN 1b <b>40 years-</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. 2 Box 222 Good Luck Road</b>				d. STREET ADDRESS <b>Rt. 2. Box 222. Good Luck Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Leo Davis Kerstetter</b>				4. DATE OF DEATH Month Day Year <b>November 14 1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-17-1876</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Davis J. Kerstetter</b>				14. MOTHER'S MAIDEN NAME <b>? Barrett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Span-American</b>		17. INFORMANT <b>Winifred K. Cutting</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiovascular renal disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>November 14, 1956</b>	
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Buried</b>		22b. DATE THEREOF <b>11-17-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS</b>				ADDRESS <b>5801 Cleveland Ave. Riverdale Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 16 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Carrie Campbell</b>			

MEDICAL CERTIFICATION

# MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John F. Kennedy		Male		35		11-17-63	
Place of Birth		Race		Occupation		Cause of Death	
New York, N.Y.		White		President of the United States		Heart disease	
Residence		Marital Status		Date of Marriage		Date of Burial	
Washington, D.C.		Married		1953		11-19-63	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	

**RECEIVED**  
NOV 16 1963  
BUREAU V. B.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the delay in writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11671 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11672  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month <b>11</b> - Day <b>4</b> - Year <b>1956</b>		5. STREET ADDRESS <b>Pine Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Herman</b> Middle <b>Joseph</b> Last <b>Kleinheitz</b>		6. DATE OF BIRTH <b>Sept. 19, 1906</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <b>50</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Woodworker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cabinet Making</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ignac Kleinheitz</b>		14. MOTHER'S MAIDEN NAME <b>Frederika Bohler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Louise Kleinheitz; <del>xxx</del></b>		Address <b>4014 Lawrence St. Colmar Manor, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO (b) <b>Gunshot wound of chest (percussion gun)</b> DUE TO (c) <b>Self inflicted wound of chest</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflicted wound of chest</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11-4-</b> o. m. <b>1956</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) <b>Colmar Manor</b> (County) <b>Pr. Geo.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John T. Maloney</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>November 5, 1956</b>	
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 7, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Port Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) <b>Colmar Manor, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 8 '56</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. Keloney, A.D.	
Sex		Male	
Race		White	
Date of Birth		Sept. 19, 1900	
Place of Birth		U.S.A.	
Occupation		Carpenter	
Usual Residence		1111 E. Baltimore St., Baltimore, Md.	
Cause of Death		Hemorrhage and shock	
Manner of Death		Suicide (by gunshot wound of chest)	
Place of Death		1111 E. Baltimore St., Baltimore, Md.	
Time of Death		Self-inflicted wound of chest	
Signature of Examiner		John T. Keloney, A.D.	
Signature of Coroner		John T. Keloney, A.D.	
Signature of Physician		John T. Keloney, A.D.	

**RECEIVED**  
 NOV 8 1956  
**BUREAU V. S.**

## 11672 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item: 3: G 213 5-9-57 L

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sandra</b> Middle <b>Kaye</b> Last <b>Knisley</b>		4. DATE OF DEATH Month <b>November</b> Day <b>8</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-12-52</b>
9. AGE (In years last birthday) <b>3</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Franklin Knisley</b>		14. MOTHER'S MAIDEN NAME <b>Gloria W. Reely</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Julian O. Knisley; same address</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral contusions; multiple lacerations and fractures</b> DUE TO (b) <b>Automobile accident</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b></b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in automobile in collision with truck</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11:00</b> p. m. <b>11-6-56</b> 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Lanham, Pr. Geo. Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John T. Maloney</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED <b>November 8, 1956</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 10 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Christa Church</b>		22d. LOCATION (City, town, or county) (State) <b>Laurel, Howard Co. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry J. Connelley</b>		24. REC'D BY REGISTRAR <b>NOV 15 56</b>	
ADDRESS <b>Laurel, Md</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Leach</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**RECEIVED**  
 NOV 15 1956  
**BUREAU - V. R.**

Person in automobile in collision with truck

Automobile accident

Cerebral contusions; multiple lacerations and fractures

Injury to pelvis; same as above

Charles Franklin Butler

Charles A. Butler

None

None

Barland

Female

White

11-12-32

3

11

Barland

Barland

Barland

Barland General Hospital

Barland General Hospital

2 days

Barland

Barland

Barland

1  
15  
00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11632 CERTIFICATE OF DEATH

11674  
245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PR. GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>4 mos.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville, MD.</u>			
				d. STREET ADDRESS <u>7002 20th Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>NANCY</u> Middle <u>ELNORA</u> Last <u>LACEY</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>21</u> Year <u>1956.</u>			
5. SEX <u>FE.</u>	6. COLOR OR RACE <u>WH.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 7, 1871</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>CHARLES FRANKS</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET NALLS.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. —		17. INFORMANT <u>Daughter—Mrs. J. Rupertus</u> Address <u>7002 20th Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic-hypertensive heart dis.</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 wks.</u> <u>years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
				20f. (City or town) —		(County) (State)	
21. I certify that I attended the deceased from <u>Feb 22</u> , 19 <u>56</u> , to <u>Nov 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 21</u> , 19 <u>56</u> , and that death occurred at <u>1:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William F. Simpson, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>6216 N.H. Ave., NE.</u> DATE SIGNED <u>11/21/56</u>			
PHYSICIAN'S NAME (Type) <u>William F. Simpson Jr.</u>				<u>Washington, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Leesburg, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 26 1956</u>		24b. REGISTRAR'S SIGNATURE <u>James Lacey</u>	

CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED JAMES EARL RAY		DATE OF DEATH JUNE 28, 1968	
AGE 35		SEX MALE	
RACE WHITE		EDUCATION HIGH SCHOOL	
BIRTH DATE JAN 1, 1933		BIRTH PLACE MOBILE, ALABAMA	
MARRIAGE MARRIED		SPOUSE'S NAME JANE RAY	
OCCUPATION CONGRESSMAN		RESIDENCE WASHINGTON, D.C.	

CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERMEDIATE CAUSE HYPERTENSION	
FUNDAMENTAL CAUSE ARTERIOSCLEROSIS		PRE-EXISTING DISEASES HYPERTENSION, CORONARY ARTERY DISEASE	
DATE OF DEATH JUNE 28, 1968		PLACE OF DEATH WASHINGTON, D.C.	
DECEASED'S SIGNATURE JAMES EARL RAY		WITNESSES' SIGNATURES JANE RAY, JAMES EARL RAY	

DECEASED'S SIGNATURE JAMES EARL RAY		WITNESSES' SIGNATURES JANE RAY, JAMES EARL RAY	
DATE OF DEATH JUNE 28, 1968		PLACE OF DEATH WASHINGTON, D.C.	
DECEASED'S SIGNATURE JAMES EARL RAY		WITNESSES' SIGNATURES JANE RAY, JAMES EARL RAY	
DATE OF DEATH JUNE 28, 1968		PLACE OF DEATH WASHINGTON, D.C.	

DECEASED'S SIGNATURE JAMES EARL RAY		WITNESSES' SIGNATURES JANE RAY, JAMES EARL RAY	
DATE OF DEATH JUNE 28, 1968		PLACE OF DEATH WASHINGTON, D.C.	
DECEASED'S SIGNATURE JAMES EARL RAY		WITNESSES' SIGNATURES JANE RAY, JAMES EARL RAY	
DATE OF DEATH JUNE 28, 1968		PLACE OF DEATH WASHINGTON, D.C.	

DECEASED'S SIGNATURE JAMES EARL RAY		WITNESSES' SIGNATURES JANE RAY, JAMES EARL RAY	
DATE OF DEATH JUNE 28, 1968		PLACE OF DEATH WASHINGTON, D.C.	
DECEASED'S SIGNATURE JAMES EARL RAY		WITNESSES' SIGNATURES JANE RAY, JAMES EARL RAY	
DATE OF DEATH JUNE 28, 1968		PLACE OF DEATH WASHINGTON, D.C.	

BUREAU V. 1

JUN 29 1968

RECEIVED

DECEASED'S SIGNATURE JAMES EARL RAY		WITNESSES' SIGNATURES JANE RAY, JAMES EARL RAY	
DATE OF DEATH JUNE 28, 1968		PLACE OF DEATH WASHINGTON, D.C.	
DECEASED'S SIGNATURE JAMES EARL RAY		WITNESSES' SIGNATURES JANE RAY, JAMES EARL RAY	
DATE OF DEATH JUNE 28, 1968		PLACE OF DEATH WASHINGTON, D.C.	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11724

## CERTIFICATE OF DEATH

11675

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9222 Defense Highway		d. STREET ADDRESS 9222 Defense Highway	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Langkham		4. DATE OF DEATH Month Nov. Day 25 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 19, 1879
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Baltimore County		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis Koester		14. MOTHER'S MAIDEN NAME Catherine Baier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs Lula Patrick 9222 Defense Highway,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of Stomach and generalized Carcinomatosis (c)		INTERVAL BETWEEN ONSET AND DEATH Few hours 10 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 20, 1956, to Nov. 25, 1956, that I last saw the deceased alive on Nov. 20, 1956, and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H. James Kurtz		DATE SIGNED 11/25/56	
PHYSICIAN'S NAME (Type) H. James Kurtz		ADDRESS (Street, city or town, state) RFD Bowie Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 28, 1956	
22c. NAME OF CEMETERY OR CREMATORY Zion Evan. Lut. Ch.		22d. LOCATION (City, town, or county) (State) Stemmers Run, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran 3000 E. Baltimore St.		24a. REC'D BY REGISTRAR DATE NOV 28 1956	
24b. REGISTRAR'S SIGNATURE Carrie Campbell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11676

## 11725 CERTIFICATE OF DEATH

Reg. Dist. No. 243

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (RURAL)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Antonio</u> Middle _____ Last <u>Lemus</u>				<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/30/1883</u>	
9. AGE (In years last birthday) yrs. <u>72</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Havana, Cuba</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Cuba</u>		13. FATHER'S NAME <u>Francisco Lemus</u>		14. MOTHER'S MAIDEN NAME <u>Anastasia Leon</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>262-07-7412A</u>		17. INFORMANT <u>Decedent</u>		Address _____		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary tuberculosis, far advanced</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>July 3</u> , 19 <u>56</u> , to <u>November 21</u> 19 <u>56</u> , that I last saw the deceased alive on <u>November 21</u> , 19 <u>56</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Daniel Leo Finucane</u> M.D.				ADDRESS (Street, city or town, state) <u>Glenn Dale, Maryland</u>		DATE SIGNED <u>11/21/56</u>	
PHYSICIAN'S NAME (Type) <u>Daniel Leo Finucane</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) _____			
22b. DATE THEREOF <u>11/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) <u>WASH.</u> (State) <u>D.C.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Malvan &amp; Lehey Inc. 424 R St. N.W.</u> ADDRESS _____	
24a. REC'D BY REGISTRAR <u>11/22/56</u>		24b. REGISTRAR'S SIGNATURE <u>Walt Weiss</u>		25. DATE _____			

BUREAU V. S.

NOV 29 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11726 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11677

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lewisdale-Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>4 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2433 Chapman Road</b>		d. STREET ADDRESS <b>2433 Chapman Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Franklin</b> Last <b>Loveless</b>		4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24, 1898</b>
9. AGE (in years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Resturaunt</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Loveless</b>		14. MOTHER'S MAIDEN NAME <b>Rose Beall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-03-6053</b>	
17. INFORMANT <b>Mrs. Doris Merrill; Same address</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Tamponade</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rupture of left ventricle</b> DUE TO (c) <b>Cardiovascular renal disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>November 27, 1956</b>	
22a. BURIAL, CREMATION, or DISPOSAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 29-1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lewis-Hyattsville Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Donaldson</b>		24a. REC'D BY REGISTRAR DATE <b>Nov 30, 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>Mrs. Jan. Severe</b>		24c. REGISTRAR'S SIGNATURE <b>Walter</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased [Illegible]		Sex Male		Race White		Date of Birth April 26, 1898		Date of Death November 21, 1956	
Usual Residence [Illegible]		Present Residence [Illegible]		Cause of Death [Illegible]		Manner of Death [Illegible]		Place of Death [Illegible]	
Signature of Medical Examiner [Illegible]		Signature of Coroner [Illegible]		Signature of Registrar [Illegible]		Signature of [Illegible]		Signature of [Illegible]	
Address of Medical Examiner [Illegible]		Address of Coroner [Illegible]		Address of Registrar [Illegible]		Address of [Illegible]		Address of [Illegible]	

RECEIVED  
 DEC 3 1956  
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11673 CERTIFICATE OF DEATH

11678

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Ind.</u>		c. LENGTH OF STAY IN 1b <u>12 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>Box - 164 - Rt. 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Marjorie</u> Middle <u>(M.M.)</u> Last <u>MacKlin</u>		4. DATE OF DEATH Month <u>November</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-83</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>NORTH WALES, ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JAMES ELLIS POTTER</u>		14. MOTHER'S MAIDEN NAME <u>JANE ELIZABETH JONES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-44-2702A</u>	
17. INFORMANT <u>AILEEN STOOPS</u>		Address <u>Box 164 Route 1 - LANHAM, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic glomerulonephritis</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Rheumatoid arthritis - Cortisone withdrawal</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 2, 1956</u> , to <u>Nov. 14, 1956</u> , that I last saw the deceased alive on <u>Nov. 13, 1956</u> , and that death occurred at <u>9 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Reilly</u> M.D.		ADDRESS (Street, city or town, state) <u>2409 Vermont St., Landover Hills, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Reilly, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 16, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamberlin</u>		ADDRESS <u>Riverdale, Md.</u>	
24a. REC'D BY REGISTRAR <u>Nov 16 56</u>		24b. REGISTRAR'S SIGNATURE	

(1944)

Mr James Watson Wood, Esq.

Nov 27-41-202- Aircon 2000 - Box 10 for 1/100000

104 16 1536

19. 11. 1940 - 19. 11. 1940

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

11679  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>915 62nd Place</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Donald</b> Middle <b>Massey</b> Last				4. DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Black</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 24 1956</b>	
9. AGE (In years last birthday) yrs. <b>2</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>15</b> Hours <b>19</b> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Issac Massey</b>				14. MOTHER'S MAIDEN NAME <b>Pearl Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <b>Rosal Massey</b> Address <b>915-62nd Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchio pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>491x</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>11/11</b> , 19 <b>55</b> to <b>11/15</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov 15</b> , 19 <b>56</b> , and that death occurred at <b>11:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Tick Bergemann</b> M.D.				DATE SIGNED <b>11/15/56</b>			
PHYSICIAN'S NAME (Type) <b>Tick Bergemann</b>				ADDRESS (Street, city or town, state) <b>4314 Falls Church Highway</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>11-19-56</b>				22b. DATE THEREOF <b>11-19-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>mt almet</b>	
22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry S. Washington</b> ADDRESS <b>467 N st NW</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 20 '56</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	

2297205XV2

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
PLACE OF BIRTH		CITY		STATE	
DATE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
EDUCATION		RELIGION		MARITAL STATUS	
PREVIOUS ILLNESS		TREATMENT		HISTORICAL	
FAMILY HISTORY		SOCIAL HISTORY		PHYSICAL EXAMINATION	
LABORATORY TESTS		X-RAY		PATHOLOGICAL FINDINGS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		OFFICIAL SEAL	

RECEIVED  
NOV 30 1956  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12819

## 11675 CERTIFICATE OF DEATH

Reg. Dist. No.

<p>1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u></p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md.</u></p>				<p>c. LENGTH OF STAY IN 1b <u>3 hours</u></p>			
<p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Hospital</u></p>				<p>e. STREET ADDRESS <u>Route #1</u></p>			
<p>3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>McGowan</u></p>				<p>4. DATE OF DEATH Month <u>11</u> Day <u>27</u> Year <u>1956</u></p>			
<p>5. SEX <u>Female</u></p>		<p>6. COLOR OR RACE <u>white</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>11-27-56</u></p>	
<p>9. AGE (In years last birthday) <u>3 hrs</u> yrs.</p>		<p>IF UNDER 1 YEAR Months <u>3</u> Days <u>10</u></p>		<p>IF UNDER 24 HRS. Hours <u>3</u> Min. <u>10</u></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u></p>		<p>11. BIRTHPLACE (State or foreign country)</p>		<p>12. CITIZEN OF WHAT COUNTRY?</p>	
<p>13. FATHER'S NAME <u>Clenard Cleve and McGowan</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>Dorothy McGowan</u></p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO.</p>			
<p>17. INFORMANT <u>Mother as of above</u></p>				<p>Address</p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (800gms. -- 12½ inches)</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p>							
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>							
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u></p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I attended the deceased from <u>Nov 27, 1956</u>, to <u>Nov 27, 1956</u>, that I last saw the deceased alive on <u>Nov 27, 1956</u>, and that death occurred at <u>9:54</u> M, from the causes and on the date stated above.</p>							
<p>ACTUAL SIGNATURE <u>J. M. Warren</u> M.D.</p>				<p>ADDRESS (Street, city or town, state) <u>Cheverly Md.</u></p>			
<p>PHYSICIAN'S NAME (Type) <u>J. M. Warren</u></p>				<p>DATE SIGNED <u>11/27/56</u></p>			
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>22b. DATE THEREOF <u>Dec 1956</u></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <u>Brown's Chapel</u></p>		<p>22d. LOCATION (City, town, or county) (State) <u>Cheverly Md.</u></p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry N Penn Jr Supt</u></p>				<p>ADDRESS <u>2077 336 XVO</u></p>			
<p>24a. REC'D BY REGISTRAR DATE <u>DEC 31 56</u></p>				<p>24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u></p>			

RECEIVED  
DEC 31 1956  
BUREAU V. S.

DEC 31 1956



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12 Filed 206 11-9-56 et

## CERTIFICATE OF DEATH

Reg. Dis. 11680 245

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>15 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4016 Longfellow St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Susan</b> Middle <b>Elizabeth</b> Last <b>Michael</b>		4. DATE OF DEATH Month <b>November</b> Day <b>2</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 1, 1869</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>56</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Shawn</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Harry Shaw</b>		Address <b>Same as #2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Cardiovascular Renal</b> DUE TO (c) <b>Disease</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Hyattsville</b>		(County) (State)	
21. I certify that I attended the deceased from <b>4-2</b> , 19 <b>40</b> , to <b>11-2</b> , 19 <b>56</b> that I last saw the deceased alive on <b>11-2</b> , 19 <b>56</b> , and that death occurred at <b>10:30 P. M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Aaron Deitz</b>		DATE SIGNED <b>11-3-56</b>	
PHYSICIAN'S NAME (Type) <b>AARON DEITZ, M.D.</b>		ADDRESS (Street, city or town, state) <b>Hyattsville Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/5/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b>		24a. REC'D BY REGISTRAR <b>James Leroy</b>	
ADDRESS <b>Frederick - Md.</b>		DATE <b>5 Nov. 1956</b>	

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John Doe		1956	
Age		Sex	
35 years		Male	
Race		Marital Status	
White		Single	
Place of Birth		Usual Residence	
Maryland		Baltimore	
Cause of Death		Manner of Death	
Heart Disease		Natural	
Immediate Cause		Underlying Cause	
Myocardial Infarction		Coronary Atherosclerosis	
Date of Report		Signature of Physician	
1956		John Doe, M.D.	
Signature of Registrar		Signature of Medical Examiner	
John Doe		John Doe	

BUREAU V. S.

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# 1 11678 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

11681

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>P. G.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>8 1/2 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>C</b> Last <b>Miller</b>				4. DATE OF DEATH Month <b>11</b> Day <b>28</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-3-16</b>	
9. AGE (In years last birthday) yrs. <b>40</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>							
13. FATHER'S NAME <b>Daniel B. Murphy</b>				14. MOTHER'S MAIDEN NAME <b>Frances C. Funk</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Albert J. Miller</b> Address <b>4002 Cottage Terrace Cottage City Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>581.0</b> DUE TO <b>Diffuse Pulmonary secondary to expiration of gastric contents</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Gastritis</b> DUE TO <b>Early Portal Cirrhosis</b> (c) <b>Lithopedion</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lithopedion</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>10 hours</b> <b>1 week</b> <b>1 year</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>11/28</b> , 19 <b>56</b> , to <b>11/28</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>11/28</b> , 19 <b>56</b> , and that death occurred at <b>9:05 p.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Norman D. Comeau</b>				ADDRESS (Street, city or town, state) <b>3503 Perry St.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Norman D. Comeau</b>				DATE SIGNED <b>11/28/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/1/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank Seiers Sons Co.</b>				ADDRESS <b>3605-14 St NW</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 8 '56</b>	
						24b. REGISTRAR'S SIGNATURE <b>Reed</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>ALBERT J. MILLER</b>		2. SEX <b>MALE</b>		3. AGE <b>45</b>		4. DATE OF BIRTH <b>1911</b>		5. PLACE OF BIRTH <b>NEW YORK</b>	
6. OCCUPATION <b>LABORER</b>		7. CAUSE OF DEATH <b>HEART DISEASE</b>		8. MANNER OF DEATH <b>NATURAL</b>		9. PLACE OF DEATH <b>HOME</b>		10. DATE OF DEATH <b>DEC 3 1956</b>	
11. SIGNATURE OF PHYSICIAN <b>FRANCIS G. FRANK</b>		12. SIGNATURE OF DECEASED <b>ALBERT J. MILLER</b>		13. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		14. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		15. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>	
16. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		17. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		18. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		19. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		20. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>	
21. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		22. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		23. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		24. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		25. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>	
26. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		27. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		28. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		29. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		30. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>	
31. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		32. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		33. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		34. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		35. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>	
36. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		37. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		38. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		39. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		40. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>	
41. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		42. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		43. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		44. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		45. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>	
46. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		47. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		48. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		49. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		50. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>	
51. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		52. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		53. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		54. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		55. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>	
56. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		57. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		58. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		59. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		60. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>	
61. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		62. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		63. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		64. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		65. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>	
66. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		67. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		68. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		69. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		70. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>	
71. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		72. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		73. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		74. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		75. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>	
76. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		77. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		78. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		79. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		80. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>	
81. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		82. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		83. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		84. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		85. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>	
86. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		87. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		88. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		89. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		90. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>	
91. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		92. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		93. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		94. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		95. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>	
96. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		97. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		98. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		99. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>		100. SIGNATURE OF WITNESS <b>ALBERT J. MILLER</b>	

BUREAU V. S.

DEC 3 1956

RECEIVED

## 11677 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN lb <u>11 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. STREET ADDRESS <u>4904 Buchanan St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Paul</u> Last <u>Miller</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>7</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9 June 1913</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u>43</u> Days <u>43</u> Hours <u>43</u> Min. <u>43</u>		IF UNDER 24 HRS. Months <u>43</u> Days <u>43</u> Hours <u>43</u> Min. <u>43</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic (Bench)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Artificial Limb</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James C. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Julia M. McKenney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>579-16-9325</u>		17. INFORMANT <u>Katherine A. Miller, 4904 Buchanan St. Edmonston, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EMBOLISM</u> DUE TO <u>410X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>LEFT AURICLE THROMBOSIS</u> DUE TO <u>MITRAL STENOSIS</u> (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u> INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u> <u>YEARS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>22 OCT.</u> , 19 <u>56</u> , to <u>7 NOV.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6 NOV.</u> , 19 <u>56</u> , and that death occurred at <u>35 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>905 SHERIDAN ST. HYATTSVILLE</u> DATE SIGNED <u>11/7/1956</u>							
ACTUAL SIGNATURE <u>Henry R. Wolfe</u>				M.D. <u>905 SHERIDAN ST. HYATTSVILLE</u>			
PHYSICIAN'S NAME (Type) <u>HENRY R. WOLFE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/10/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Pr. Geo. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Company, Riverdale, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>NOV 9 '56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Paul</u>			

MEDICAL CERTIFICATION

TO REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9561 6 NOV

RECEIVED

1  
2

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11727 CERTIFICATE OF DEATH

11683

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLINTON</b>		c. LENGTH OF STAY IN 1b <b>57 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RT 1 Box 256</b>		d. STREET ADDRESS <b>RT 1 Box 256</b>	
3. NAME OF DECEASED (Type or print) <b>MARY</b> First <b>CECELIA</b> Middle <b>MULLIKIN</b> Last		4. DATE OF DEATH <b>NOV. 15</b> 19 <b>56</b> Month Day Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 14, 1880</b> 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>WASH. D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BENJAMIN PALMER</b>		14. MOTHER'S MAIDEN NAME <b>SARAH CRUBB</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. RICHARD MULLIKIN</b> Address <b>RT 1 Box 256 CLINTON, MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRO-VASCULAR ACCIDENT</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE CARDIO-VASCULAR DISEASE</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>10+ years.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTINUING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NONE</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year <b>NONE</b> 19 <b>56</b> Hour <b>NONE</b> m. <b>NONE</b>		20d. INJURY OCCURRED <b>NONE</b> While at work <b>NONE</b> Not while at work <b>NONE</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>NONE</b>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>FEB.</b> 19 <b>56</b> , to <b>NOV. 15<sup>th</sup></b> 19 <b>56</b> , that I last saw the deceased alive on <b>NOV. 14<sup>th</sup></b> 19 <b>56</b> , and that death occurred at <b>8:29 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Arthur Shaver Jr.</b> M.D. <b>Clinton, Md.</b> DATE SIGNED <b>Nov. 15, 1956</b> PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR.</b> <b>CLINTON, MD.</b> <b>NOV 15, 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 17-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Christ Church</b>		22d. LOCATION (City, town, or county) <b>Clinton</b> (State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Summers Bros</b> ADDRESS <b>1661 1st Hope</b>		24a. REC'D BY REGISTRAR <b>NOV 16 1956</b> DATE <b>RA &amp; MASH</b>	
24b. REGISTRAR'S SIGNATURE <b>Carrie Campbell</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 10a, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

12826

11678

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>38 Cheverly</b>				c. LENGTH OF STAY IN 1b <b>20 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <b>6007 L Street</b>							
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Odrick</b> Last <b>Odrick</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>30</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Black</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1897</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>McDuffie Co., Georgia</b>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Clem Hamilton</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>11678</b>			
17. INFORMANT <b>Address</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriolar Nephrosclerosis</b> DUE TO (c) <b>Arteriosclerotic Cardiovascular Renal Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic aneurysm of the abdominal aorta</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>years</b> <b>Years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>4:50 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5432 QUEEN'S CHAPEL Rd</b> DATE SIGNED <b>11/30/56</b> ACTUAL SIGNATURE <b>Ronald S. Fleischer</b> M.D. <b>HYATTSVILLE, Md</b> PHYSICIAN'S NAME (Type) <b>RONALD S. FLEISCHER</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-5-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Rhines + Co. 901-3rd St. S.W.</b> ADDRESS <b>901-3rd St. S.W.</b>				24a. REC'D BY REGISTRAR <b>DEC 7 '56</b> DATE <b>DEC 7 '56</b>		24b. REGISTRAR'S SIGNATURE <b>Overseer</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. PLACE OF DEATH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
JAMES EARL RAY		Male		35		White		Student		Memphis, Tenn.		Memphis, Tenn.		April 4, 1968		4:00 PM		Heart Disease		Suicide		[Signature]		[Signature]		[Signature]		[Signature]	
16. PLACE OF BURIAL		17. NAME OF BURIAL PLACE		18. NAME OF MINISTER		19. NAME OF CHURCH		20. NAME OF CEMETERY		21. NAME OF FUNERAL HOME		22. NAME OF CARRIER		23. NAME OF COFFIN		24. NAME OF CASKET		25. NAME OF CASKET LINEN		26. NAME OF CASKET COVER		27. NAME OF CASKET LINEN		28. NAME OF CASKET COVER		29. NAME OF CASKET LINEN		30. NAME OF CASKET COVER	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	

BUREAU V.

DEC 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11684

11679

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Avondale, Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacorda Nursing Home</u>		d. STREET ADDRESS <u>5404-21<sup>st</sup> Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NORA</u> Middle <u>A</u> Last <u>PAUL</u>		4. DATE OF DEATH Month <u>11/20/56</u> Day <u>12:30</u> Year <u>am</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-27-1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>in own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Western Run, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert F. Stabler</u>		14. MOTHER'S MAIDEN NAME <u>Artilda ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-10-7965</u>	
17. INFORMANT <u>Robert L. Paul</u>		Address <u>5404-21<sup>st</sup> Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca of Cervix</u> <u>191X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/23/56</u> , 19 <u>56</u> , to <u>11/18/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/18/56</u> , 19 <u>56</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John J. Sweeney M.D.</u>		ADDRESS (Street, city or town, state) <u>1238 Monroe St NE</u>	
DATE SIGNED <u>Wash DC</u>			
PHYSICIAN'S NAME (Type) <u>John J. Sweeney</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-23-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home</u>		ADDRESS <u>3200 R.R. Ave. Mt. Rainier, Md.</u>	
24a. REC'D BY REGISTRAR <u>Wash DC</u>		DATE NOV 26 '56	

CERTIFICATE OF DEATH

NAME OF DECEASED: **PRINCE GEORGE**  
 SEX: **MALE**  
 AGE: **31**  
 DATE OF BIRTH: **1924-04-21**  
 PLACE OF BIRTH: **Cherry**  
 OCCUPATION: **General Insurance Agent**  
 MARITAL STATUS: **Single**  
 CAUSE OF DEATH: **No**  
 PLACE OF DEATH: **Robert L. Paul 2404-31 Ave**  
 DATE OF DEATH: **April 21, 1956**  
 TIME OF DEATH: **10:30 AM**  
 SIGNATURE OF DECEASED: **Robert L. Paul**  
 SIGNATURE OF WITNESSES: **Robert L. Paul**  
 SIGNATURE OF PHYSICIAN: **Robert L. Paul**  
 SIGNATURE OF CORONER: **Robert L. Paul**

BUREAU V. S.

10V 26 1956

RECEIVED

John D. Swenson  
11-23-56  
Baltimore

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 13 & 14, Film G207, 12/4/56 bh

## CERTIFICATE OF DEATH

11685

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <span style="float: right;">11680</span> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md.</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pg.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Md.</u> d. STREET ADDRESS <u>7209 Linwood Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Edward</u> First Middle Last <u>Phillips</u> <b>4. DATE OF DEATH</b> Month <u>Nov</u> Day <u>18</u> Year <u>1956</u>				<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>5-27-1899</u> <b>9. AGE</b> (In years last birthday) <u>57</u> yrs.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>John D. Phillips</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Molly Pryor</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary occlusion syncope</u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>10/18</u> , 19 <u>56</u> to <u>11/18/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/18</u> , 19 <u>56</u> , and that death occurred at <u>10:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3404 Cheverly Ave</u> DATE SIGNED <u>11/19/56</u> ACTUAL SIGNATURE <u>John Kehoe M.D.</u> PHYSICIAN'S NAME (Type) <u>JOHN KEHOE</u> <u>3404 Cheverly Ave.</u>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>burial</u>		<b>22b. DATE THEREOF</b> <u>Nov 20, 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Washington National</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Anne Arundel Md</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>1. 10<sup>th</sup> Lee's Sons Co. 360 4<sup>th</sup> NE Wash. D.C.</u> ADDRESS				<b>24a. REC'D BY REGISTRAR</b> DATE <u>NOV 23 '56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arden</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF PHYSICIAN</p>	
<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESS</p>		<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF NEXT OF KIN</p>	
<p>17. SIGNATURE OF BURIAL OFFICIAL</p>		<p>18. SIGNATURE OF CHURCH OFFICIAL</p>		<p>19. SIGNATURE OF FUNERAL HOME</p>		<p>20. SIGNATURE OF CEMETERY</p>	
<p>21. SIGNATURE OF CORoner</p>		<p>22. SIGNATURE OF JURY</p>		<p>23. SIGNATURE OF COURT</p>		<p>24. SIGNATURE OF STATE</p>	
<p>25. SIGNATURE OF COUNTY</p>		<p>26. SIGNATURE OF CITY</p>		<p>27. SIGNATURE OF TOWNSHIP</p>		<p>28. SIGNATURE OF DISTRICT</p>	
<p>29. SIGNATURE OF PRESTBYTERY</p>		<p>30. SIGNATURE OF EPISCOPAL</p>		<p>31. SIGNATURE OF METHODIST</p>		<p>32. SIGNATURE OF LUTHERAN</p>	
<p>33. SIGNATURE OF BAPTIST</p>		<p>34. SIGNATURE OF PRESBYTERIAN</p>		<p>35. SIGNATURE OF REFORMED</p>		<p>36. SIGNATURE OF OTHER</p>	
<p>37. SIGNATURE OF OTHER</p>		<p>38. SIGNATURE OF OTHER</p>		<p>39. SIGNATURE OF OTHER</p>		<p>40. SIGNATURE OF OTHER</p>	
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<p>97. SIGNATURE OF OTHER</p>		<p>98. SIGNATURE OF OTHER</p>		<p>99. SIGNATURE OF OTHER</p>		<p>100. SIGNATURE OF OTHER</p>	

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101.23 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11681

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11686

Item 9: G207 12/6/56

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg, Md.		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4911 Taylor Street,.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg, Md.	
3. NAME OF DECEASED (Type or print) First Middle Last Milton Ellsworth Poole		4. DATE OF DEATH Month Day Year Nov 17, 1956. 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 21, 1895
9. AGE (In years last birthday) # 61 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY U S Government	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A.	
13. FATHER'S NAME Samuel Poole		14. MOTHER'S MAIDEN NAME Minnie E Becraft	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mina E. Poole		Address Bladensburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO myocardial infarction (b) nephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 8 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1959, to 11-17, 1956, that I last saw the deceased alive on 11-15, 1956, and that death occurred at 8 9 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Leonard Hays		DATE SIGNED Hyattsville, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 19, 1956	
22c. NAME OF CEMETERY OR CREMATORY George Washington		22d. LOCATION (City, town, or county) (State) Hyattsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR DATE NOV 20 1956		24b. REGISTRAR'S SIGNATURE A. H. Hedrick	

18. Maryland State Department of Health—Baltimore, 18

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11682 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11687

Reg. Dist. No. 245

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leland Memorial Hospital DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Riverdale</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b> d. STREET ADDRESS <b>4802 Calvert Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Adaire Elizabeth Preston</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>November 16 19 56</b>					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Aug. 31, 1956</b>		<b>9. AGE</b> (In years last birthday) yrs. <b>2</b> <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Richard K. Preston</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Stewart T. Berry</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Father--- Same address</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Toxemia</b> <b>491X</b> DUE TO <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> (b) <b>Bronchopneumonia</b> <b>DUE TO</b> (c)								<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>									
<b>ACTUAL SIGNATURE</b> <i>John T. Maloney</i> <b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney M.D.</b>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>11-16-56</b>				<b>DATE SIGNED</b>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)		<b>22b. DATE THEREOF</b> <b>11/19/56</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt Olivet</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Washington D. C.</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>J. Gasch's Sons Hyattsville, Md.</b>				<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>NOV 20 1956 James Leary</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. Maloney, Jr.	
Sex		Male	
Age		34	
Date of Death		April 11, 1956	
Place of Death		Home	
Cause of Death		Bronchopneumonia	
Manner of Death		Natural	
Signature of Physician		[Signature]	
Signature of Medical Examiner		[Signature]	
Date of Examination		April 11, 1956	
Place of Examination		Home	
Signature of Coroner		[Signature]	
Date of Certification		April 11, 1956	
Place of Certification		Baltimore, Maryland	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11683 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11688

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS High Bridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MOLLIE Middle (N.M.N.) PUMPHREY Last				4. DATE OF DEATH Month November Day 26th, Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1877	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lawrence Smith				14. MOTHER'S MAIDEN NAME Betty Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Edward Smith, Bowie, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 904.0 DUE TO Generalized septicaemia Conditions, if any, which gave rise to immediate cause (b) Decubital ulcers (a), stating the underlying cause last. DUE TO (c) Fracture of femur						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in home					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 8/3/56 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Bowie, Pr. Geo. Co., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/29/1956		22c. NAME OF CEMETERY OR CREMATORY Perkins Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Bowie, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE DEC 3 56		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERVIEWER		21. SIGNATURE OF INTERVIEWEE	
22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWEE		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWEE		26. SIGNATURE OF INTERVIEWER		27. SIGNATURE OF INTERVIEWEE	
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100. SIGNATURE OF INTERVIEWER		101. SIGNATURE OF INTERVIEWEE		102. SIGNATURE OF INTERVIEWER	

BUREAU V. S.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11684 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11689

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b> c. LENGTH OF STAY IN 1b <b>15 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4530 Banner Street</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b> d. STREET ADDRESS <b>4530 Banner Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>John Walter Ransom</b>		<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>1</b> Year <b>1956</b>		<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>Colored</b>			
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>January 4, 1877</b>		<b>9. AGE</b> (In years last birthday) <b>79 yrs.</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Cement work</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>N. Carolina</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Alfred Ransom</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service:		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Anna Ransom; Same address</b> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Acute congestive heart failure</b> <b>442x DUE TO</b> <b>Cardiovascular renal disease</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>DUE TO</b>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour <b>a. m.</b> <b>p. m.</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>John T. Maloney</i>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b>			
<b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>November 1, 1956</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>22b. DATE THEREOF</b> <b>11-5-56</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Lincoln Mon</b>			
<b>22d. LOCATION (City, town, or county)</b> <b>Suitland Rd. Md</b>		<b>(State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Henry S. Washington + Sons</b>		<b>ADDRESS</b> <b>467 N st. NW</b>		<b>24a. REC'D BY REGISTRAR</b> <b>NOV 7 '56</b>			
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Overman</i>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John	
Age		15 years	
Sex		Male	
Race		Colored	
Date of Death		January 1, 1977	
Place of Death		1530 Banner Street	
Cause of Death		Alcoholism	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	
Signature of Police Officer		[Signature]	
Signature of Witness		[Signature]	
Signature of Family Member		[Signature]	
Signature of Other		[Signature]	

Anna Hanson; Same address

Acute congestive heart failure  
Cardiovascular renal disease

BUREAU V. S.

NOV 7 1956

RECEIVED

John T. McInerney, M.D.

11695 CERTIFICATE OF DEATH

11690

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Riverdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5511 Nicholson St.</u>				d. STREET ADDRESS <u>5511 Nicholson St.</u>			
3. NAME OF DECEASED (Type or print) <u>RAYMOND</u> First <u>R.</u> Middle <u>H.</u> Last <u>REED</u>				4. DATE OF DEATH <u>Nov. 23 19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 26, 1892</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAT. LAUNDRY CO. D. C.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Lleuyllan T. Reed</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Kraft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>G.W. Lipscomb</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of aortic aneurysm</u> <u>442X</u> DUE TO <u>known aneurysm of aorta</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardio. revascular disease</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1945</u> to <u>Nov 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 24</u> , 19 <u>56</u> , and that death occurred at <u>7:15</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lester W. Harris</u>				ADDRESS (Street, city or town, state) <u>10111 Collesville Rd</u>		DATE SIGNED <u>11-23-56</u>	
PHYSICIAN'S NAME (Type) <u>Lester W. Harris</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Lee's Sons Co.</u> ADDRESS <u>300-4 4th St. D.C.</u>				24a. REC'D BY REGISTRAR <u>Nov 26 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Wm Jas. Severe</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

*Dr. Haloney notified as coroner and approved*

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. RACE <i>White</i>	
5. PLACE OF BIRTH <i>New York City</i>		6. DATE OF BIRTH <i>Jan 15 1910</i>		7. TIME OF DEATH <i>10:30 PM</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. PLACE OF DEATH <i>Home</i>		10. DATE OF DEATH <i>Jan 20 1956</i>		11. TIME OF DEATH <i>10:30 PM</i>		12. PLACE OF BURIAL <i>St. Mary's Cemetery</i>	
13. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>		14. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		15. NAME OF MINISTER <i>Rev. J. H. Smith</i>		16. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i>	
17. NAME OF NEXT OF KIN <i>John Doe</i>		18. NAME OF SURVIVOR <i>John Doe</i>		19. NAME OF SURVIVOR <i>John Doe</i>		20. NAME OF SURVIVOR <i>John Doe</i>	
21. NAME OF SURVIVOR <i>John Doe</i>		22. NAME OF SURVIVOR <i>John Doe</i>		23. NAME OF SURVIVOR <i>John Doe</i>		24. NAME OF SURVIVOR <i>John Doe</i>	
25. NAME OF SURVIVOR <i>John Doe</i>		26. NAME OF SURVIVOR <i>John Doe</i>		27. NAME OF SURVIVOR <i>John Doe</i>		28. NAME OF SURVIVOR <i>John Doe</i>	
29. NAME OF SURVIVOR <i>John Doe</i>		30. NAME OF SURVIVOR <i>John Doe</i>		31. NAME OF SURVIVOR <i>John Doe</i>		32. NAME OF SURVIVOR <i>John Doe</i>	
33. NAME OF SURVIVOR <i>John Doe</i>		34. NAME OF SURVIVOR <i>John Doe</i>		35. NAME OF SURVIVOR <i>John Doe</i>		36. NAME OF SURVIVOR <i>John Doe</i>	
37. NAME OF SURVIVOR <i>John Doe</i>		38. NAME OF SURVIVOR <i>John Doe</i>		39. NAME OF SURVIVOR <i>John Doe</i>		40. NAME OF SURVIVOR <i>John Doe</i>	
41. NAME OF SURVIVOR <i>John Doe</i>		42. NAME OF SURVIVOR <i>John Doe</i>		43. NAME OF SURVIVOR <i>John Doe</i>		44. NAME OF SURVIVOR <i>John Doe</i>	
45. NAME OF SURVIVOR <i>John Doe</i>		46. NAME OF SURVIVOR <i>John Doe</i>		47. NAME OF SURVIVOR <i>John Doe</i>		48. NAME OF SURVIVOR <i>John Doe</i>	
49. NAME OF SURVIVOR <i>John Doe</i>		50. NAME OF SURVIVOR <i>John Doe</i>		51. NAME OF SURVIVOR <i>John Doe</i>		52. NAME OF SURVIVOR <i>John Doe</i>	
53. NAME OF SURVIVOR <i>John Doe</i>		54. NAME OF SURVIVOR <i>John Doe</i>		55. NAME OF SURVIVOR <i>John Doe</i>		56. NAME OF SURVIVOR <i>John Doe</i>	
57. NAME OF SURVIVOR <i>John Doe</i>		58. NAME OF SURVIVOR <i>John Doe</i>		59. NAME OF SURVIVOR <i>John Doe</i>		60. NAME OF SURVIVOR <i>John Doe</i>	
61. NAME OF SURVIVOR <i>John Doe</i>		62. NAME OF SURVIVOR <i>John Doe</i>		63. NAME OF SURVIVOR <i>John Doe</i>		64. NAME OF SURVIVOR <i>John Doe</i>	
65. NAME OF SURVIVOR <i>John Doe</i>		66. NAME OF SURVIVOR <i>John Doe</i>		67. NAME OF SURVIVOR <i>John Doe</i>		68. NAME OF SURVIVOR <i>John Doe</i>	
69. NAME OF SURVIVOR <i>John Doe</i>		70. NAME OF SURVIVOR <i>John Doe</i>		71. NAME OF SURVIVOR <i>John Doe</i>		72. NAME OF SURVIVOR <i>John Doe</i>	
73. NAME OF SURVIVOR <i>John Doe</i>		74. NAME OF SURVIVOR <i>John Doe</i>		75. NAME OF SURVIVOR <i>John Doe</i>		76. NAME OF SURVIVOR <i>John Doe</i>	
77. NAME OF SURVIVOR <i>John Doe</i>		78. NAME OF SURVIVOR <i>John Doe</i>		79. NAME OF SURVIVOR <i>John Doe</i>		80. NAME OF SURVIVOR <i>John Doe</i>	
81. NAME OF SURVIVOR <i>John Doe</i>		82. NAME OF SURVIVOR <i>John Doe</i>		83. NAME OF SURVIVOR <i>John Doe</i>		84. NAME OF SURVIVOR <i>John Doe</i>	
85. NAME OF SURVIVOR <i>John Doe</i>		86. NAME OF SURVIVOR <i>John Doe</i>		87. NAME OF SURVIVOR <i>John Doe</i>		88. NAME OF SURVIVOR <i>John Doe</i>	
89. NAME OF SURVIVOR <i>John Doe</i>		90. NAME OF SURVIVOR <i>John Doe</i>		91. NAME OF SURVIVOR <i>John Doe</i>		92. NAME OF SURVIVOR <i>John Doe</i>	
93. NAME OF SURVIVOR <i>John Doe</i>		94. NAME OF SURVIVOR <i>John Doe</i>		95. NAME OF SURVIVOR <i>John Doe</i>		96. NAME OF SURVIVOR <i>John Doe</i>	
97. NAME OF SURVIVOR <i>John Doe</i>		98. NAME OF SURVIVOR <i>John Doe</i>		99. NAME OF SURVIVOR <i>John Doe</i>		100. NAME OF SURVIVOR <i>John Doe</i>	

BUREAU V. S.

NOV 27 1956

RECEIVED

*Handwritten notes and signatures on the right margin.*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11634 CERTIFICATE OF DEATH

11691

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia			
c. LENGTH OF STAY IN 1b 1 year				d. STREET ADDRESS 3655 North 21th Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6302 23rd Avenue, .				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rose Middle Mary Last Reilly				4. DATE OF DEATH Month Nov 13, 1956 Day 19 Year			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 17, 1879	
9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY self		11. BIRTHPLACE (State or foreign country) Ireland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME John Moran				14. MOTHER'S MAIDEN NAME Rose Dugan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Anna M. Talone 6302 23rd avenue, . W Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day 10 years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct Nov 1955, to Nov 13, 1956, that I last saw the deceased alive on Nov 13, 1956, and that death occurred at M, from the causes and on the date stated above. ACTUAL SIGNATURE Leon L. Gallin M.D. 7206 Cokesville Road University Hills Md. PHYSICIAN'S NAME (Type) Leon L. Gallin							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Transit Nov 14, 1956		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Philadelphia		22d. LOCATION (City, town, or county) Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE J. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE 19 1956		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11692

## 11636 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince Georges Dev. Hosp.</i>		d. STREET ADDRESS <i>Route 2</i>	
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>W.</i> Last <i>REVELL</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>7</i> Year <i>1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/16/79</i>
9. AGE (In years last birthday) <i>77</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <i>Shoemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Contractor</i>	
11. BIRTHPLACE (State or foreign country) <i>Canada</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph Revell</i>		14. MOTHER'S MAIDEN NAME <i>Mary Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-07-7002</i>	
17. INFORMANT <i>Hannie Revell</i>		Address <i>Clinton Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac insufficiency</i> DUE TO <i>400.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i> DUE TO <i>Tumorous cell carcinoma of</i> (c) <i>Bladder with metastasis</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a) <i>Bladder with metastasis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3 Nov.</i> , 1956, to <i>7 Nov.</i> , 1956, that I last saw the deceased alive on <i>6 Nov.</i> , 1956, and that death occurred at <i>9 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry R. Wolfe</i> M.D. <i>618 N. High St. - Sheepshead</i>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>HENRY R. WOLFE</i>			
22a. REMOVAL, CREMATION, or BURIAL <i>Burial</i>		22b. DATE THEREOF <i>11-10-1956</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Johns</i>		22d. LOCATION (City, town, or county) (State) <i>Clinton Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mattlingly Funeral Home</i>		ADDRESS <i>31-11th St. E</i>	
24a. REC'D BY REGISTRAR <i>Rehman</i>		24b. REGISTRAR'S SIGNATURE	
DATE <i>Nov 9 '56</i>			

CERTIFICATE OF DEATH

1. PLACE OF DEATH Home		2. COUNTY OF DEATH BALTIMORE	
3. CITY OR TOWN OF DEATH BALTIMORE		4. STREET ADDRESS 1234 N. WOLFE ST.	
5. NAME OF DECEASED JOHN J. WOLFE		6. SEX Male	
7. AGE 45		8. RACE White	
9. OCCUPATION Carpenter		10. MARITAL STATUS Married	
11. DATE OF DEATH Jan 15, 1956		12. TIME OF DEATH 10:30 AM	
13. CAUSE OF DEATH Myocardial Infarction		14. PLACE OF INTERMENT St. Mary's Cemetery	
15. SIGNATURE OF DECEASED John J. Wolfe		16. SIGNATURE OF WITNESSES John J. Wolfe, Mary J. Wolfe	
17. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		18. SIGNATURE OF REGISTRAR J. H. Smith	

BUREAU W. H.

JAN 9 1956

RECEIVED

WOLFE, R. W.

WOLFE, R. W.

11728

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11693

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

242

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>		c. LENGTH OF STAY IN 1b <u>Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6121 Allentown Road S.E.</u>				d. STREET ADDRESS <u>6121 Allentown Road S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Emma Richards</u>				4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 31, 1880</u>	9. AGE (In years last birthday) <u>76 yrs.</u>	IF UNDER 1 YEAR Months <u>      </u> Days <u>      </u>	IF UNDER 24 HRS. Hours <u>      </u> Min. <u>      </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Llewellen Watson</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Walker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>      </u>		17. INFORMANT <u>Washington 22, D.C.</u> <u>Helen B. Bailey 5981 Allentown Road S.E.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u>      </u>							INTERVAL BETWEEN ONSET AND DEATH <u>      </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>      </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>      </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>      </u> a. m. <u>      </u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>      </u>		20f. (City or town) (County) (State) <u>      </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>November 5, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 8-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel E. Church</u>		22d. LOCATION (City, town, or county) (State) <u>Horse Head Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Burr</u>				ADDRESS <u>1061- Good Hope Rd</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	
				24a. REC'D BY REGISTRAR <u>NOV 7</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BATHING  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV 2 1956

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

11694

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5700 Baltimore avenue		d. STREET ADDRESS 5700 Baltimore avenue	
3. NAME OF DECEASED (Type or print) First Anna Lewis Rose Middle Last		4. DATE OF DEATH Nov 8, 1956 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1869
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Harrison S. Bowen		14. MOTHER'S MAIDEN NAME Mary Julia Prettyman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs Charles White		Address College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Congestive Heart Failure General arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 week 10 years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY a. H. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1941 to Nov 8, 1956, that I last saw the deceased alive on Nov 6, 1956, and that death occurred at 2 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE LW Malen MD		ADDRESS (Street, city or town, state) Riverdale, Md	
DATE SIGNED 11-9-56			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov 10, 1956	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington D. C.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR NOV 12 1956		24b. REGISTRAR'S SIGNATURE James Leaver	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		65		M		W		1891		BALTIMORE		MD		USA		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH	
RETIRED		HIGH SCHOOL		MARRIED		METHODIST		HEART DISEASE		NATURAL		3 WEEKS		NOV 13 1956		BALTIMORE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF CHURCH CLERK		SIGNATURE OF BURIAL CLERK		SIGNATURE OF FUNERAL HOME	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

NOV 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

11695

23

1. PLACE OF DEATH o. COUNTY Prince Geo. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY P. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5410 Odell Rd.		d. STREET ADDRESS 5410 Odell Rd.	
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last ROSS		4. DATE OF DEATH Nov. 23 1936	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/24/1873
9. AGE (In years last birthday) 83		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Miller		14. MOTHER'S MAIDEN NAME Pheobe Stockett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Emily Ross		Address 5410 Odell Rd. Beltsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 Mo. 15 Yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myelitis. Asthma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/1/40 to 11/23/56, that I last saw the deceased alive on 11/22/56, 19, and that death occurred at 10:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. M. Warren M.D.		DATE SIGNED 11/23/56	
PHYSICIAN'S NAME (Type) J.M. Warren		Laurel, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) 11-26-56		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Queens Chapel		22d. LOCATION (City, town, or county) (State) Mt Airy Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington		ADDRESS 467 N. St. NW	
24a. REC'D BY REGISTRAR DATE NOV 27 1956		24b. REGISTRAR'S SIGNATURE John D. Smith	

BUREAU V. S.

NOV 27 1956

RECEIVED

## 11697 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY P. G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cherverly				c. LENGTH OF STAY IN 1b 2 Hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. STREET ADDRESS 7119 Tucker's Road, S. E.			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Mamie Savoy				4. DATE OF DEATH Month Day Year 11 28 19 56			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-17-92	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY home			
11. BIRTHPLACE (State or foreign country) Charles Co., Md.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Thomas Proctor				14. MOTHER'S MAIDEN NAME Caroline Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Address Gladys Proctor 7123 Tucker Rd. Wash., D. C.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO congestive heart failure (b) DUE TO Hypertension & atherosclerotic cardio-vascular disease (c) DUE TO Vascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) years INTERVAL BETWEEN ONSET AND DEATH 146.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			(County)		(State)		
21. I certify that I attended the deceased from 11-28, 1956, to 11-28, 1956, that I last saw the deceased alive on 11-28, 1956, and that death occurred at 6:10 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Ronald S. Fleischer M.D.				ADDRESS (Street, city or town, state) 5432 Chesapeake Rd. DATE SIGNED 4/29/82			
PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER				1444 North Ave. 4/29/82			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/1/56		22c. NAME OF CEMETERY OR CREMATORY St Peter's Cem.		22d. LOCATION (City, town, or county) (State) Waldorf, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harold General Home ADDRESS				24a. REC'D BY REGISTRAR DATE DEC 3 58		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11698

## CERTIFICATE OF DEATH

11697

Reg. Dist. No. 2 42

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAPITAL HIGHTS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAPITAL HEIGHTS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>802 51 AVE</u>				d. STREET ADDRESS <u>802 51st AVE</u>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM JOHN SCHMIDT</u>				4. DATE OF DEATH <u>Nov 20</u> 19 <u>54</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 4, 1888</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STENOGRAPHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH NEWS</u>		11. BIRTHPLACE (State or foreign country) <u>CHICAGO ILL</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>JOHN SCHMIDT</u>			
14. MOTHER'S MAIDEN NAME <u>MARY NAGEL</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>272-10-8161</u>				17. INFORMANT <u>PEARL SCHMIDT, 802 51st Ave, Cap Hgts, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung with metastases</u> DUE TO <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u> (b) <u>260X</u> (c) <u>260X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>8 months</u> 2 years				INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u> <u>2 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Nov 12</u> , 19 <u>54</u> to <u>Nov 20</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>Nov 20</u> , 19 <u>54</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>William Brainin</u> M.D. <u>6124 Central Ave</u>				PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11-21-54</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Wash National</u>				22d. LOCATION (City, town, or county) (State) <u>Smithland, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co., Washington D.C.</u>				24a. REC'D BY REGISTRAR <u>11-21-54</u>			
24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>							

WESTLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS  
 1955 CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		5-1-28		MOBILE, ALABAMA		6-23-68		MEMPHIS, TENNESSEE	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		MOTHER'S NAME		FATHER'S NAME	
MARRIED		1-1-50		MEMPHIS, TENNESSEE		JAMES EARL RAY		JAMES EARL RAY	
EDUCATION		SCHOOL ATTENDED		DEGREE		OCCUPATION		INDUSTRY	
HIGH SCHOOL		MEMPHIS, TENNESSEE		BACHELOR OF ARTS		ATTORNEY		MEMPHIS, TENNESSEE	
RELIGION		METHODIST		PASTOR		MILITARY SERVICE		ARMY	
MILITARY SERVICE		ARMY		1946-1948		REMARKS		HEART DISEASE	
CAUSE OF DEATH		HEART DISEASE		CORONARY ARTERY DISEASE		MANNER OF DEATH		NATURAL	
DATE OF DEATH		6-23-68		PLACE OF DEATH		HOSPITAL		MEMPHIS, TENNESSEE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

NOV 23 1956

RECEIVED

## 11730 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND <u>MD</u>		STATE <u>MD</u>		COUNTY <u>Pr. Geo.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <u>Lehman</u>		<u>35 yr</u>		TOWN <u>Lehman</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>Lincoln Park</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>11-20-1956</u>			
<u>Price Andrew Scott</u>							
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Nov. 25 1866</u>	9. AGE last birthday: <u>89</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months	Days	Hours	Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Minister</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Religion</u>		11. BIRTHPLACE (State or foreign country): <u>VA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME: <u>—</u>				14. MOTHER'S MAIDEN NAME: <u>—</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Herman Scott Socks - Lehman MD</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>450.0</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Cardiac Arrest</u>							
DUE TO							
(B) <u>Generalized Arteriosclerosis</u>							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/19, 1956</u> to <u>11/20, 1956</u> , that I last saw the deceased alive on <u>11/20, 1956</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Dr. Henry G. Wisner M.D.</u>		<u>9005 Volta St</u>		<u>Lehman MD</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov. 24 1956</u>		<u>Lincoln Cemetery</u>		<u>Suitland MD.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Nov. 20, 1956</u>		<u>Mrs. Jas. Senere</u>		<u>W. E. Jarvis Co.</u>		<u>1432 York St. N.W.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 27 1956

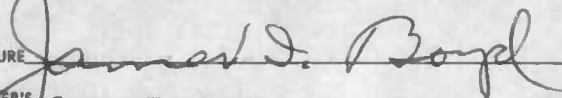
RECEIVED

W. E. Lawrence 143-11-111

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11731 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Near Fort Washington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac River</b>				d. STREET ADDRESS <b>Quarters #84, Bolling AF Base</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>James Clyde</b> Middle <b>Selser</b> Last <b>Jr</b>				<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>18</b> Year <b>1936</b>				
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>10 Sep 1912</b>		
<b>9. AGE</b> (In years last birthday) <b>44 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.		<b>10. AGE</b> (In years last birthday) <b>44 yrs.</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Pilot, USAF</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>USAF</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>New Orleans, Louisiana</b>		
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>United States</b>				<b>13. FATHER'S NAME</b> <b>James C. Selser Sr.</b>				
<b>14. MOTHER'S MAIDEN NAME</b> <b>Ernestine Gourrier</b>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>				
<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> Address <b>Official Records</b>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Drowning</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Occupant of an airplane that crashed in the river</b>				
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>6:30 p. m. 11/18 1936</b>				<b>20d. INJURY OCCURRED</b> While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>River Oxon Hill P. G. Md</b>		
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
<b>ACTUAL SIGNATURE</b>  <b>EXAMINER'S NAME (Type)</b> <b>James I. Boyd</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				
<b>22a. DATE THEREOF</b> <b>Nov. 23, 1936</b>				<b>22b. NAME OF CEMETERY</b> <b>Arlington National</b>		<b>22c. LOCATION</b> (City, town, or county) (State) <b>Arlington, Virginia</b>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W.W. CHAMBERS CO., 517 11th St., S.E. Wash., D.C.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>NOV 26 1936</b>				

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM 15  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John J. Harrison		Male		35		10-25-55	
Place of Death		Cause of Death		Manner of Death		Occupation	
Home		Heart Disease		Natural		Farmer	
Residence		History of Illness		Previous Injuries		Drugs Taken	
1234 Main St.		Began 10 days before death		None		None	
City		Treatment		Postmortem Exam.		Signature of Examiner	
Birmingham		None		Yes		J. H. Smith	
State		Remarks		Signature of Coroner		Signature of Physician	
Alabama		None		J. H. Smith		J. H. Smith	

BUREAU V. S.

NOV 26 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11689

## CERTIFICATE OF DEATH

Reg. Dist. No.

11700

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>University Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>(W.M.N.)</u> Last <u>Shea</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-1889</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES LOUETT</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH (UNKNOWN)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Augustus W. Shea</u>		Address <u>4403 TUCKERMAN ST</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u> (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>2 YRS</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 HRS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> to <u>11/15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/15</u> , 19 <u>56</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Comeau</u> M.D. <u>3503 Bay St.</u>		DATE SIGNED <u>11/15/56</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMEAU</u>		ADDRESS <u>MT POIRIER MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/17/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fair Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>College Anne Rb Co, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Charles Co - Gaithersburg Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>11/20/56</u>		24b. REGISTRAR'S SIGNATURE <u>W. Charles</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(4.4.4)

1822 13

Phases 100-11  
Alfred University (Albany)

No. Name Address or Place of Residence

**BUREAU V. S.**

1956 MAY 20

RECEIVED

W. B. Charles & Co. - Portland, Me.  
March 14/75  
First Income Tax

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11732 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11701

Reg. Dist. No.

242

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b> c. LENGTH OF STAY IN 1b <b>transient</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>George Palmer Highway &amp; new Rt. 50</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b> d. STREET ADDRESS <b>9706 52nd Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Mark</b> Middle <b>Bass</b> Last <b>Shively</b>				<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>28</b> Year <b>19 56</b>					
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>9-10-10</b>		<b>9. AGE</b> (In years last birthday) <b>46</b> yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Cab driver</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Transportation</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Indiana</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Louis Shively</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Nora Canine</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Glenn Shively; 405 W. Grove Boul. Alexandria, Va.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO <b>Carbonmonoxide poisoning</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Inhalation of fumes from automobile exhaust.</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>11-28 56</b> Hour a. m. p. m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		<b>20f. (City or town) (County) (State)</b> <b>Lanham Pr. Geo. Md.</b>	
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Noturol causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input checked="" type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>									
<b>ACTUAL SIGNATURE</b> <i>John T. Maloney</i> <b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <b>November 28, 1956</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>CREMATION</b>				<b>22b. DATE THEREOF</b> <b>12/1/1956</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>CEDAR HILL CREMATORY</b>		<b>22d. LOCATION (City, town, or county) (State)</b> <b>SUITLAND, PRINCE GEORGES, MARYLAND</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>MARTIN W. HYSOONG COMPANY 1300 N. ST., N.W. WASH. D.C.</b>				<b>ADDRESS</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DEC 3 1956</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Carrie Campbell</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

NOVEMBER 30 1956

BUREAU V. 8

11-30-56

Examination of traces from automobile exhaust.

Carbonaceous poisoning

Asphyxia

John Shively; 105 N. Grove South, Birmingham, Ala.

John Shively

New Canine

Cap driver

Transportation

Indiana

White

9-10-10

10

100

Shively

November 28

3000 32nd Avenue

George Robert Shively, New York, N.Y.

Transient

College Park

Prince Georges

Prince Georges

Prince Georges

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11733

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film 6207 11-26-50 et

Reg. Dist. No.

V30

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>		c. LENGTH OF STAY IN 1b <b>Transient</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route 1 and Garrett Avenue</b>			d. STREET ADDRESS <b>4102 Gallatin Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Ernest</b> Middle <b>Burett</b> Last <b>Shumaker</b>			4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>1956</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>Separated</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-18-10</b>	9. AGE (In years last birthday) <b>46</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Lester Shumaker</b>		
14. MOTHER'S MAIDEN NAME <b>Bessie Elizabeth Bost</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		
16. SOCIAL SECURITY NO. <b>248-07-8933</b>		17. INFORMANT <b>Lester Shumaker--627 Sedgefield Dr. Warwick,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Compound, comminuted fracture of skull</b> (a), stating the underlying cause lost. DUE TO (c) <b>Automobile accident</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Va.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile overturned on highway</b>			
20c. TIME OF INJURY Month <b>11</b> Day <b>18</b> Year <b>56</b> Hour <b>1.45</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>	
20f. (City or town) <b>Beltsville, Pr. Geo., Maryland</b>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 19, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Colmar Manor, Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 20 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>John D. Smith</b>		DATE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the funeral home, in writing, the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. Haganey, M.D.	
Residence		11-18-50	
Place of Death		11-18-50	
Cause of Death		Hemorrhage and shock	
Manner of Death		Accident	
Date of Death		11-18-50	
Age		3-11-10	
Sex		Male	
Race		White	
Birthplace		North Carolina	
Occupation		Resident Physician	
Signature of Physician		[Signature]	
Signature of Medical Examiner		[Signature]	

BUREAU V. B.

NOV 20 1950

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11703

## 11734 CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Park.</u>		c. LENGTH OF STAY IN 1b <u>4 months</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Park.</u>		d. STREET ADDRESS <u>6515-D St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6515-D St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>BENJAMIN</u> Last <u>SMITH.</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 29, 1878</u> yrs. <u>78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Greenville, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Smith</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Phillips</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Donald Smith - 6515-D St, Md Park, Md.</u>	
17. INFORMANT Address <u>Donald Smith - 6515-D St, Md Park, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with Failure</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>2 weeks</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 15</u> , 195 <u>3</u> , to <u>Nov 26</u> , 195 <u>6</u> , that I last saw the deceased alive on <u>Nov 26</u> , 195 <u>6</u> , and that death occurred at <u>4:50 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6124 Central Ave</u> DATE SIGNED <u>11/26/56</u>			
ACTUAL SIGNATURE <u>William Brainin</u> M.D.		DATE SIGNED <u>11/26/56</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM BRAININ</u>		Capitol Hotel Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-29-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or county) (State) <u>BOONTON N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lees - 300-4th St NE Wash, D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE 11-29-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

BUREAU V. S.

DEC 3 1956

RECEIVED

1-25

11690

## CERTIFICATE OF DEATH

Reg. Dist. No.

242

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmount Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmount Heights</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Lee &amp; Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Hattie</u> First <u>Smith</u> Middle <u>Smith</u> Last				4. DATE OF DEATH <u>Nov. 23</u> Month <u>Nov.</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jul 23 1903</u> 53 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Fairfax</u>				14. MOTHER'S MAIDEN NAME <u>Emily Bowman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>1103 Addison Rd NE</u>		17. INFORMANT <u>Ernest Smith</u> Address <u>1103 Addison Rd NE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x</u> DUE TO <u>Congestive Heart Failure</u> acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Disease</u> unknown DUE TO (c) <u>unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1948</u> to <u>Nov. 23, 1956</u> , that I last saw the deceased alive on <u>1956</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1948</u> to <u>Nov. 23, 1956</u> , that I last saw the deceased alive on <u>1956</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John W. Robinson</u> , M.D. <u>1001 Eastern Ave. NE</u> <u>11/23/56</u>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>John W. Robinson, M.D.</u> <u>Washington 27, D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-27-56</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat.</u>		22d. LOCATION (City, town, or county) <u>Arlington Virginia</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henny Washington</u> ADDRESS <u>467 7th NW</u>				24a. REC'D BY REGISTRAR <u>NOV 27 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES W. WILSON		63		M		W		1893		BALTIMORE		MD		U.S.A.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT		CORONER		BURIAL PLACE	
NOV 27 1956		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		DR. J. W. WILSON		J. W. WILSON		BALTIMORE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF CORONER		SIGNATURE OF BURIAL PLACE		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF OFFICIAL	

RECEIVED  
NOV 27 1956  
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11635 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11705

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Dist. of Col.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>1 week</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5801 42nd Avenue</b>				d. STREET ADDRESS <b>1261 Kearney Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Adelaide</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>11</b> - Day <b>9</b> - Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-12-74</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Borden Smith</b>				14. MOTHER'S MAIDEN NAME <b>Josaphine Cormack</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Claire Krogmann; same address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac tamponade</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Rupture of Aortic aneurism</b> (a), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>11-9-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Nov 13 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glennwood</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. Shaffell</b>		ADDRESS <b>475 H-21 NW 206</b>		24a. REC'D BY REGISTRAR <b>NOV 13 1956</b>		24b. REGISTRAR'S SIGNATURE <b>James Leaver</b>	

MARY AND STATE DEPARTMENT OF HEALTH - BIRTH, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John J. Jones	
Age		1 year	
Sex		Male	
Race		White	
Birth Date		1-1-1935	
Birth Place		St. Louis, Mo.	
Residence		1234 Main St., St. Louis, Mo.	
Cause of Death		Sudden Infant Death Syndrome	
Date of Death		11-1-1935	
Time of Death		11:00 AM	
Place of Death		Home	
Signature of Medical Examiner		J. H. Smith	
Signature of Coroner		J. H. Smith	

BUREAU V. 2

NOV 13 1935

RECEIVED

John J. Jones

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11691

CERTIFICATE OF DEATH

11706

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>			
c. LENGTH OF STAY IN 1b <u>26hrs. &amp; 25 min.</u>				d. STREET ADDRESS <u>4010 38th St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Theodosia</u> Last <u>Speake</u>				4. DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-12-75</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Oliver A Donn</u>				14. MOTHER'S MAIDEN NAME <u>Susan Mahoney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Hospital Record Cheverly, Maryland.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure with bilateral hydrothorax</u> DUE TO (b) <u>Old myocardial fibrosis and recent infarction</u> DUE TO (c) <u>Coronary arteriosclerotic heart disease</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the stomach with gastro-intestinal hemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>48 hours</u> <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 10</u> , 19 <u>54</u> , to <u>Nov. 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 23</u> , 19 <u>56</u> , and that death occurred at <u>4:10 p.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. C. Hageage</u>				ADDRESS (Street, city or town, state) <u>3308 Perry St., Mt. Rainier, Md.</u>			
PHYSICIAN'S NAME (Type) <u>C. C. Hageage M. D.</u>				DATE SIGNED <u>11/24/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 27, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Basch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 27 56</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

# CERTIFICATE OF DEATH

REG. DIV. 10

1. PLACE OF DEATH		2. COUNTY	
3. MARITAL STATUS		4. OCCUPATION	
5. DATE OF BIRTH		6. DATE OF DEATH	
7. SEX		8. RACE	
9. HEIGHT		10. WEIGHT	
11. COLOR OF EYES		12. COLOR OF HAIR	
13. COLOR OF SKIN		14. BLOOD TYPE	
15. CAUSE OF DEATH		16. MANNER OF DEATH	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF CORONER	
21. SIGNATURE OF JUDGE		22. SIGNATURE OF CLERK	
23. SIGNATURE OF NOTARY		24. SIGNATURE OF SHERIFF	
25. SIGNATURE OF DEPUTY SHERIFF		26. SIGNATURE OF JURY	
27. SIGNATURE OF JURY		28. SIGNATURE OF JURY	
29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
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97. SIGNATURE OF JURY		98. SIGNATURE OF JURY	
99. SIGNATURE OF JURY		100. SIGNATURE OF JURY	

BUREAU V. S.

NOV 07 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11707

## 11692 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>14 Hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Girl</b> Last <b>Stahly</b>		4. DATE OF DEATH Month <b>15</b> Day <b>Nov</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 Nov 1956</b>
9. AGE (In years last birthday) yrs. <b>14</b>		10. IF UNDER 1 YEAR Months <b>14</b> Days <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Edward Stahly</b>		14. MOTHER'S MAIDEN NAME <b>Virginia France</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Father</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>atelectasis</b> <b>762.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>congenital non-respiratory</b> DUE TO (c) <b>hypoxia</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 14</b> , 19 <b>56</b> , to <b>Nov. 15</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov. 15</b> , 19 <b>56</b> , and that death occurred at <b>2,40A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John W. Perkins</b>		ADDRESS (Street, city or town, state) <b>5301 Hamlet 58</b>	
PHYSICIAN'S NAME (Type) <b>Francis J. Collins</b>		DATE SIGNED <b>11/15/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/16/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>		ADDRESS <b>3821 14th St. N.W. D.C.</b>	
24a. REC'D BY REGISTRAR <b>Nov 20 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 45		4. RACE White		5. BIRTH DATE 10-15-1910		6. BIRTH PLACE Maryland	
7. DECEASED DATE 11-10-1956		8. DECEASED TIME 10:00 AM		9. DECEASED PLACE Home		10. DECEASED TIME 11:00 AM		11. DECEASED PLACE Home		12. DECEASED TIME 12:00 PM	
13. DECEASED TIME 1:00 PM		14. DECEASED PLACE Home		15. DECEASED TIME 2:00 PM		16. DECEASED PLACE Home		17. DECEASED TIME 3:00 PM		18. DECEASED PLACE Home	
19. DECEASED TIME 4:00 PM		20. DECEASED PLACE Home		21. DECEASED TIME 5:00 PM		22. DECEASED PLACE Home		23. DECEASED TIME 6:00 PM		24. DECEASED PLACE Home	
25. DECEASED TIME 7:00 PM		26. DECEASED PLACE Home		27. DECEASED TIME 8:00 PM		28. DECEASED PLACE Home		29. DECEASED TIME 9:00 PM		30. DECEASED PLACE Home	
31. DECEASED TIME 10:00 PM		32. DECEASED PLACE Home		33. DECEASED TIME 11:00 PM		34. DECEASED PLACE Home		35. DECEASED TIME 12:00 AM		36. DECEASED PLACE Home	
37. DECEASED TIME 1:00 AM		38. DECEASED PLACE Home		39. DECEASED TIME 2:00 AM		40. DECEASED PLACE Home		41. DECEASED TIME 3:00 AM		42. DECEASED PLACE Home	
43. DECEASED TIME 4:00 AM		44. DECEASED PLACE Home		45. DECEASED TIME 5:00 AM		46. DECEASED PLACE Home		47. DECEASED TIME 6:00 AM		48. DECEASED PLACE Home	
49. DECEASED TIME 7:00 AM		50. DECEASED PLACE Home		51. DECEASED TIME 8:00 AM		52. DECEASED PLACE Home		53. DECEASED TIME 9:00 AM		54. DECEASED PLACE Home	
55. DECEASED TIME 10:00 AM		56. DECEASED PLACE Home		57. DECEASED TIME 11:00 AM		58. DECEASED PLACE Home		59. DECEASED TIME 12:00 PM		60. DECEASED PLACE Home	
61. DECEASED TIME 1:00 PM		62. DECEASED PLACE Home		63. DECEASED TIME 2:00 PM		64. DECEASED PLACE Home		65. DECEASED TIME 3:00 PM		66. DECEASED PLACE Home	
67. DECEASED TIME 4:00 PM		68. DECEASED PLACE Home		69. DECEASED TIME 5:00 PM		70. DECEASED PLACE Home		71. DECEASED TIME 6:00 PM		72. DECEASED PLACE Home	
73. DECEASED TIME 7:00 PM		74. DECEASED PLACE Home		75. DECEASED TIME 8:00 PM		76. DECEASED PLACE Home		77. DECEASED TIME 9:00 PM		78. DECEASED PLACE Home	
79. DECEASED TIME 10:00 PM		80. DECEASED PLACE Home		81. DECEASED TIME 11:00 PM		82. DECEASED PLACE Home		83. DECEASED TIME 12:00 AM		84. DECEASED PLACE Home	
85. DECEASED TIME 1:00 AM		86. DECEASED PLACE Home		87. DECEASED TIME 2:00 AM		88. DECEASED PLACE Home		89. DECEASED TIME 3:00 AM		90. DECEASED PLACE Home	
91. DECEASED TIME 4:00 AM		92. DECEASED PLACE Home		93. DECEASED TIME 5:00 AM		94. DECEASED PLACE Home		95. DECEASED TIME 6:00 AM		96. DECEASED PLACE Home	
97. DECEASED TIME 7:00 AM		98. DECEASED PLACE Home		99. DECEASED TIME 8:00 AM		100. DECEASED PLACE Home		101. DECEASED TIME 9:00 AM		102. DECEASED PLACE Home	
103. DECEASED TIME 10:00 AM		104. DECEASED PLACE Home		105. DECEASED TIME 11:00 AM		106. DECEASED PLACE Home		107. DECEASED TIME 12:00 PM		108. DECEASED PLACE Home	
109. DECEASED TIME 1:00 PM		110. DECEASED PLACE Home		111. DECEASED TIME 2:00 PM		112. DECEASED PLACE Home		113. DECEASED TIME 3:00 PM		114. DECEASED PLACE Home	
115. DECEASED TIME 4:00 PM		116. DECEASED PLACE Home		117. DECEASED TIME 5:00 PM		118. DECEASED PLACE Home		119. DECEASED TIME 6:00 PM		120. DECEASED PLACE Home	
121. DECEASED TIME 7:00 PM		122. DECEASED PLACE Home		123. DECEASED TIME 8:00 PM		124. DECEASED PLACE Home		125. DECEASED TIME 9:00 PM		126. DECEASED PLACE Home	
127. DECEASED TIME 10:00 PM		128. DECEASED PLACE Home		129. DECEASED TIME 11:00 PM		130. DECEASED PLACE Home		131. DECEASED TIME 12:00 AM		132. DECEASED PLACE Home	
133. DECEASED TIME 1:00 AM		134. DECEASED PLACE Home		135. DECEASED TIME 2:00 AM		136. DECEASED PLACE Home		137. DECEASED TIME 3:00 AM		138. DECEASED PLACE Home	
139. DECEASED TIME 4:00 AM		140. DECEASED PLACE Home		141. DECEASED TIME 5:00 AM		142. DECEASED PLACE Home		143. DECEASED TIME 6:00 AM		144. DECEASED PLACE Home	
145. DECEASED TIME 7:00 AM		146. DECEASED PLACE Home		147. DECEASED TIME 8:00 AM		148. DECEASED PLACE Home		149. DECEASED TIME 9:00 AM		150. DECEASED PLACE Home	
151. DECEASED TIME 10:00 AM		152. DECEASED PLACE Home		153. DECEASED TIME 11:00 AM		154. DECEASED PLACE Home		155. DECEASED TIME 12:00 PM		156. DECEASED PLACE Home	
157. DECEASED TIME 1:00 PM		158. DECEASED PLACE Home		159. DECEASED TIME 2:00 PM		160. DECEASED PLACE Home		161. DECEASED TIME 3:00 PM		162. DECEASED PLACE Home	
163. DECEASED TIME 4:00 PM		164. DECEASED PLACE Home		165. DECEASED TIME 5:00 PM		166. DECEASED PLACE Home		167. DECEASED TIME 6:00 PM		168. DECEASED PLACE Home	
169. DECEASED TIME 7:00 PM		170. DECEASED PLACE Home		171. DECEASED TIME 8:00 PM		172. DECEASED PLACE Home		173. DECEASED TIME 9:00 PM		174. DECEASED PLACE Home	
175. DECEASED TIME 10:00 PM		176. DECEASED PLACE Home		177. DECEASED TIME 11:00 PM		178. DECEASED PLACE Home		179. DECEASED TIME 12:00 AM		180. DECEASED PLACE Home	
181. DECEASED TIME 1:00 AM		182. DECEASED PLACE Home		183. DECEASED TIME 2:00 AM		184. DECEASED PLACE Home		185. DECEASED TIME 3:00 AM		186. DECEASED PLACE Home	
187. DECEASED TIME 4:00 AM		188. DECEASED PLACE Home		189. DECEASED TIME 5:00 AM		190. DECEASED PLACE Home		191. DECEASED TIME 6:00 AM		192. DECEASED PLACE Home	
193. DECEASED TIME 7:00 AM		194. DECEASED PLACE Home		195. DECEASED TIME 8:00 AM		196. DECEASED PLACE Home		197. DECEASED TIME 9:00 AM		198. DECEASED PLACE Home	
199. DECEASED TIME 10:00 AM		200. DECEASED PLACE Home		201. DECEASED TIME 11:00 AM		202. DECEASED PLACE Home		203. DECEASED TIME 12:00 PM		204. DECEASED PLACE Home	
205. DECEASED TIME 1:00 PM		206. DECEASED PLACE Home		207. DECEASED TIME 2:00 PM		208. DECEASED PLACE Home		209. DECEASED TIME 3:00 PM		210. DECEASED PLACE Home	
211. DECEASED TIME 4:00 PM		212. DECEASED PLACE Home		213. DECEASED TIME 5:00 PM		214. DECEASED PLACE Home		215. DECEASED TIME 6:00 PM		216. DECEASED PLACE Home	
217. DECEASED TIME 7:00 PM		218. DECEASED PLACE Home		219. DECEASED TIME 8:00 PM		220. DECEASED PLACE Home		221. DECEASED TIME 9:00 PM		222. DECEASED PLACE Home	
223. DECEASED TIME 10:00 PM		224. DECEASED PLACE Home		225. DECEASED TIME 11:00 PM		226. DECEASED PLACE Home		227. DECEASED TIME 12:00 AM		228. DECEASED PLACE Home	
229. DECEASED TIME 1:00 AM		230. DECEASED PLACE Home		231. DECEASED TIME 2:00 AM		232. DECEASED PLACE Home		233. DECEASED TIME 3:00 AM		234. DECEASED PLACE Home	
235. DECEASED TIME 4:00 AM		236. DECEASED PLACE Home		237. DECEASED TIME 5:00 AM		238. DECEASED PLACE Home		239. DECEASED TIME 6:00 AM		240. DECEASED PLACE Home	
241. DECEASED TIME 7:00 AM		242. DECEASED PLACE Home		243. DECEASED TIME 8:00 AM		244. DECEASED PLACE Home		245. DECEASED TIME 9:00 AM		246. DECEASED PLACE Home	
247. DECEASED TIME 10:00 AM		248. DECEASED PLACE Home		249. DECEASED TIME 11:00 AM		250. DECEASED PLACE Home		251. DECEASED TIME 12:00 PM		252. DECEASED PLACE Home	
253. DECEASED TIME 1:00 PM		254. DECEASED PLACE Home		255. DECEASED TIME 2:00 PM		256. DECEASED PLACE Home		257. DECEASED TIME 3:00 PM		258. DECEASED PLACE Home	
259. DECEASED TIME 4:00 PM		260. DECEASED PLACE Home		261. DECEASED TIME 5:00 PM		262. DECEASED PLACE Home		263. DECEASED TIME 6:00 PM		264. DECEASED PLACE Home	
265. DECEASED TIME 7:00 PM		266. DECEASED PLACE Home		267. DECEASED TIME 8:00 PM		268. DECEASED PLACE Home		269. DECEASED TIME 9:00 PM		270. DECEASED PLACE Home	
271. DECEASED TIME 10:00 PM		272. DECEASED PLACE Home		273. DECEASED TIME 11:00 PM		274. DECEASED PLACE Home		275. DECEASED TIME 12:00 AM		276. DECEASED PLACE Home	
277. DECEASED TIME 1:00 AM		278. DECEASED PLACE Home		279. DECEASED TIME 2:00 AM		280. DECEASED PLACE Home		281. DECEASED TIME 3:00 AM		282. DECEASED PLACE Home	
283. DECEASED TIME 4:00 AM		284. DECEASED PLACE Home		285. DECEASED TIME 5:00 AM		286. DECEASED PLACE Home		287. DECEASED TIME 6:00 AM		288. DECEASED PLACE Home	
289. DECEASED TIME 7:00 AM		290. DECEASED PLACE Home		291. DECEASED TIME 8:00 AM		292. DECEASED PLACE Home		293. DECEASED TIME 9:00 AM		294. DECEASED PLACE Home	
295. DECEASED TIME 10:00 AM		296. DECEASED PLACE Home		297. DECEASED TIME 11:00 AM		298. DECEASED PLACE Home		299. DECEASED TIME 12:00 PM		300. DECEASED PLACE Home	

BUREAU V. S.

NOV 20 1956

RECEIVED

## 11735 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leintrist Heights</u>		c. LENGTH OF STAY IN 1b <u>5 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7207 Alpine Street</u>		e. STREET ADDRESS <u>7207 Alpine Street</u>	
3. NAME OF DECEASED (Type or print) <u>Pearly</u> First <u>Adelma</u> Middle <u>Stillwell</u> Last		4. DATE OF DEATH <u>Nov</u> Month <u>23</u> Day <u>1956</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18, 1894</u>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <u>62</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
13. FATHER'S NAME <u>James J. Higgs</u>		14. MOTHER'S MAIDEN NAME <u>Mary Talley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>James J. Higgs</u>	
17. INFORMANT <u>Cledus Hunter Stillwell</u>		Address <u>same as old</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James J. Doyle</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Nov 23, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11-26-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Bladenburg Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>		ADDRESS <u>Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>4-27-56</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 5

NOV 29 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11693 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11709

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Dist. of Col.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene LeLand Memorial Hospital</b>		d. STREET ADDRESS <b>2627 Sherman Ave., N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Lewis</b> Last <b>Strother</b>		4. DATE OF DEATH Month <b>November</b> Day <b>3</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-11-08</b>
9. AGE (In years last birthday) <b>47 yrs.</b>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waiter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cafeteria</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William R. Strother</b>		14. MOTHER'S MAIDEN NAME <b>Kaoka Leavitt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Gerald Strother</b>		Address <b>4306 S. Dakota Ave. Wash., D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral sinus thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fractured skull</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Collision between auto., in which deceased was riding as a passenger and a tree.</b>	
20c. TIME OF INJURY Month, Day, Year <b>5:45 p.m. 11-2- 1956</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) <b>Beltsville, Pr. Geo., Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>November 3, 1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11.7.56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Carver Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Muirkirk, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert G. McGuire</b>		24a. REC'D BY REGISTRAR <b>NOV 7 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>James Hoover</b>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased

2. Sex

3. Age

4. Residence

5. Occupation

6. Cause of Death

7. Date of Death

8. Place of Death

9. Date of Burial

10. Place of Burial

11. Signature of Medical Examiner

12. Date of Report

13. Signature of Registrar

14. Date of Report

15. Signature of Medical Examiner

16. Signature of Registrar

17. Signature of Medical Examiner

18. Signature of Registrar

19. Signature of Medical Examiner

20. Signature of Registrar

21. Signature of Medical Examiner

22. Signature of Registrar

23. Signature of Medical Examiner

24. Signature of Registrar

25. Signature of Medical Examiner

BUREAU V. 3

26. Signature of Registrar

27. Signature of Medical Examiner

NOV 7 1956

RECEIVED

John F. Minter, Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11694 CERTIFICATE OF DEATH

11710  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chantilly, Md.		c. LENGTH OF STAY IN 1b 26 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen. Hosp.		d. STREET ADDRESS 7307 Forest Road	
3. NAME OF DECEASED (Type or print) Martha Sullivan		4. DATE OF DEATH November 21, 19 56	
5. SEX 7	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1925
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Non Home	9. AGE (In years last birthday) 31 yrs.
11. BIRTH PLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Rudolph Lucke		14. MOTHER'S MAIDEN NAME Grace Bartram	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Joseph A. Sullivan, Kent Village Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Intracranial Hemorrhage 330x DUE TO Ruptured Aneurysm of Circle of Willis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 26 hours (c) 26 hours		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 20, 1956, to Nov 21, 1956, that I last saw the deceased alive on Nov 21, 1956, and that death occurred at 4:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ronald S. Fleischer M.D.		ADDRESS (Street, city or town, state) 1432 QUEEN'S CHAPEL Rd. DATE SIGNED 11/21/56	
PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER		HYATTSVILLE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Transit 11/26/56		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery		22d. LOCATION (City, town, or county) (State) Hurley, Wisconsin	
23. FUNERAL DIRECTOR'S SIGNATURE A. Gasch's Sons Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE NOV 26 56	
		24b. REGISTRAR'S SIGNATURE	



Items 8,9: G206 11-23-56L

Item 8: G207 11-23-56L

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <b>11695 MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Del.</u> b. COUNTY <u>Monroe</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Columbia</u> <b>51X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince George General</u>		d. STREET ADDRESS <u>528 Main Street</u>	
3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>B.</u> Last <u>SWEETWOOD</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1882</u> <u>March 31 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Kanas</u>
13. FATHER'S NAME <u>Unk.</u>		14. MOTHER'S MAIDEN NAME <u>Unk.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. INFORMANT <u>M. Charlotte Crow</u> <u>4550 Newton St. Bladensburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Bilateral Pneumonitis</u> <u>492x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 Hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 1</u> , 19 <u>56</u> , to <u>Nov. 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 9</u> , 19 <u>56</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. C. Hageage</u>		ADDRESS (Street, city or town, state) <u>Mt. Rainier, Md.</u>	
PHYSICIAN'S NAME (Type) <u>C. C. Hageage M.D.</u>		DATE SIGNED <u>11/9/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Transit</u>	22b. DATE THEREOF <u>11/13/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Palmyra Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Belville Illinois</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 13 56</u>	24b. REGISTRAR'S SIGNATURE <u>Outback</u>

**BUREAU V. S.**

NOV 13 1956

RECEIVED

## 11695 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>38 Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>77 Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Tayman</b> Last <b>Tayman</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>16</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar 20 1887</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>William Tayman</b>				14. MOTHER'S MAIDEN NAME <b>UNK.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>William A. Tayman</b> Address <b>WASH., D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DISSECTING ANEURYSM THORACIC AORTA</b> <b>451X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS AND HYPERTENSION</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>35 HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>7</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 15</b> , 19 <b>56</b> , to <b>Nov 16</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov 16</b> , 19 <b>56</b> , and that death occurred at <b>11.00P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5802 BALTO AV - HYATTSVILLE, MD.</b> DATE SIGNED <b>11-17-56</b> ACTUAL SIGNATURE <b>[Signature]</b> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-21-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SE Mary's Com.</b>		22d. LOCATION (City, town, or county) (State) <b>PISCATAWAY MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hunt Funeral Home</b>				ADDRESS <b>WALDORF, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 20 '56</b>	
				24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>WILLIAM A. JAGMAN</b>		2. SEX <b>MALE</b>		3. AGE <b>38</b>		4. DATE OF BIRTH <b>APR 10 1927</b>		5. PLACE OF BIRTH <b>NEW YORK CITY</b>		6. RACE <b>WHITE</b>		7. OCCUPATION <b>SALES</b>		8. MARITAL STATUS <b>MARRIED</b>		9. DATE OF DEATH <b>APR 10 1965</b>		10. PLACE OF DEATH <b>HOME</b>		11. CAUSE OF DEATH <b>HEART DISEASE</b>		12. MANNER OF DEATH <b>NATURAL</b>		13. SIGNATURE OF PHYSICIAN <b>[Signature]</b>		14. SIGNATURE OF REGISTRAR <b>[Signature]</b>		15. SIGNATURE OF WITNESS <b>[Signature]</b>		16. SIGNATURE OF DECEASED <b>[Signature]</b>	
17. FULL NAME OF DECEASED <b>WILLIAM A. JAGMAN</b>		18. SEX <b>MALE</b>		19. AGE <b>38</b>		20. DATE OF BIRTH <b>APR 10 1927</b>		21. PLACE OF BIRTH <b>NEW YORK CITY</b>		22. RACE <b>WHITE</b>		23. OCCUPATION <b>SALES</b>		24. MARITAL STATUS <b>MARRIED</b>		25. DATE OF DEATH <b>APR 10 1965</b>		26. PLACE OF DEATH <b>HOME</b>		27. CAUSE OF DEATH <b>HEART DISEASE</b>		28. MANNER OF DEATH <b>NATURAL</b>		29. SIGNATURE OF PHYSICIAN <b>[Signature]</b>		30. SIGNATURE OF REGISTRAR <b>[Signature]</b>		31. SIGNATURE OF WITNESS <b>[Signature]</b>		32. SIGNATURE OF DECEASED <b>[Signature]</b>	

BUREAU V. S.

NOV 20 1956

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND HEALTH DEPARTMENT. IT IS NOT VALID FOR OTHER PURPOSES. IT IS NOT VALID FOR THE PURPOSES OF THE MARYLAND HEALTH DEPARTMENT. IT IS NOT VALID FOR OTHER PURPOSES. IT IS NOT VALID FOR THE PURPOSES OF THE MARYLAND HEALTH DEPARTMENT. IT IS NOT VALID FOR OTHER PURPOSES.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11713

11640

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		c. LENGTH OF STAY IN 1b <u>3115-Vernum</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JULIA C Thompson</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9-1892</u>
9. AGE (In years lost birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Woodbridge Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Barkley H. Horner</u>		14. MOTHER'S MAIDEN NAME <u>Emily Hartcraft</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>James A. Thompson</u>		Address <u>3115-Vernum St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.V.A.</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arteriosclerotic disease</u> (c) <u>Coronary Heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>11-29-56</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-11-1956</u> to <u>11-30-1956</u> , that I last saw the deceased alive on <u>11-30-56</u> , and that death occurred at <u>4:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George J. Haggage</u> M.D. <u>3717-38th Ave</u>		DATE SIGNED <u>11/30/56</u>	
PHYSICIAN'S NAME (Type) <u>GEORGE J. HAGGAGE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Dec 3-1956</u>		22b. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln</u>	
22c. LOCATION (City, town, or county) <u>Bladensburg Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Seebombo</u>		ADDRESS <u>300-4 St N.E. Wash DC</u>	
24a. REC'D BY REGISTRAR <u>DATE Dec 3 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severa</u>	

BUREAU V. S.

DEC 4 1956

RECEIVED

11736

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CORAL HILLS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CORAL HILLS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5211 P STREET S.E.</u>		d. STREET ADDRESS <u>5211 P STREET S.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>MAE</u> Last <u>VAN HORN</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 8, 1865</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL GLAVIN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>EDWARD D. VAN HORN</u> Address <u>5211 P ST. S.E. CORAL HILLS.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO (b) <u>with myocardial degeneration</u> 10 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>904.9 Fractured Humerus on Nov 8, 1956.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1946</u> , to <u>Nov 30, 1956</u> , that I last saw the deceased alive on <u>November 30, 1956</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>11/30/56</u>			
ACTUAL SIGNATURE <u>William Brainin</u> M.D. <u>6124 Central Ave</u>			
PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-3-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Washington D.C.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>REC-5</u> 1956 <u>d. H. Hedrick</u>	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 5 1956

RECEIVED

## 11737 CERTIFICATE OF DEATH

11715

Reg. Dist. No.

242

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If instituting: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LANHAM</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LANHAM</b>			
c. LENGTH OF STAY IN 1b <b>11 yrs</b>				d. STREET ADDRESS <b>9408 WASHINGTON BLVD</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Arthur Francis Vaudrevil</b>				4. DATE OF DEATH <b>NOV 23 1956</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB 5, 1911</b>	
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FLORIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FLOWER</b>		11. BIRTHPLACE (State or foreign country) <b>WORCESTER, MASS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ARTHUR VAUDREUIL</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>034-09-6274</b>		17. INFORMANT <b>LILLIAN VAUDREUIL</b> Address <b>LANHAM, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Insufficiency</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cirrhosis of Liver</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe Secondary Anemia</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Nov. 21, 1956</b> , to <b>Nov. 23, 1956</b> , that I last saw the deceased alive on <b>Nov. 21, 1956</b> , and that death occurred at <b>10:50</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H James Kurtz</b> M.D.				DATE SIGNED <b>Nov 23 1956</b>			
PHYSICIAN'S NAME (Type) <b>H James Kurtz</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11-26-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Notre Dame Cemetery Worcester Mass</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co</b> ADDRESS <b>Riversdale Md</b>				24a. REC'D BY REGISTRAR <b>DATE 11-27-56</b>		24b. REGISTRAR'S SIGNATURE <b>Carrie Campbell</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED  
NOV 29 1956  
BUREAU V. S.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11738

## CERTIFICATE OF DEATH

11716

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>PRINCE GEORGE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>PRINCE GEORGE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LANDOVER HILLS</u>		LENGTH OF STAY (in this place) <u>12 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LANDOVER HILLS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4107 BEALL ST.</u>				STREET ADDRESS (If rural give location) <u>4107 BEALL ST.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>WILLIAM WEISMAN</u>				<b>4. DATE OF DEATH</b> (Month) <u>Nov.</u> (Day) <u>19</u> (Year) <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAY 29 1869</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHRISTIAN WEISMAN</u>				14. MOTHER'S MAIDEN NAME <u>MARY LOUDENSLAGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-20-7491 A.</u>		17. INFORMANT & ADDRESS <u>MRS. R. JACKSON 4107 BEALL ST.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
1420.1 IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Thrombosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Coronary Artery Disease</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 1, 1956</u> , to <u>Nov 19, 1956</u> , that I last saw the deceased alive on <u>Nov 19, 1956</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert R. Bailey MD</u>				ADDRESS (Street, city, town, state) <u>2409 Varnum St. Landover Hills Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11-21-56</u>		NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE Md.</u>	
24. REC'D BY REGISTRAR <u>NOV 21 '56</u>		REGISTRAR'S SIGNATURE <u>W. Leach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schwab</u>		ADDRESS <u>2101 Frederick Ave.</u>	

# CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. DATE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESS

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CLERK

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

RECEIVED

NOV 21 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11697 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11717

Reg. Dist. No.

731

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>Transient</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>1415 Dukeland St.</b>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Robert</b> Last <b>White</b>				4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25, 1916</b>		9. AGE (In years last birthday) <b>40</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>American Oil Co.</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Will White</b>				14. MOTHER'S MAIDEN NAME <b>Addie Gywnn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Addie White 133 Quincy Pl. N.E. Wash. D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severence of descending aorta</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile collision</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>5.00 p.m. 11-18-56</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Beltsville, Pr. Geo, Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney MD.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>November 18, 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 24, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>		22d. LOCATION (City, lawn, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles B. Lewis</b>				ADDRESS <b>1639 N. Broadway</b>		24a. REC'D BY REGISTRAR <b>Nov. 20, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Hedrick</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BATHING 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name		John T. Jones	
Age		35	
Sex		Male	
Race		White	
Birth Date		July 25, 1916	
Birth Place		U.S.A.	
Residence		Truck River	
Occupation		Truck Driver	
Cause of Death		Overdose and shock	
Manner of Death		Accidental	
Signature of Examiner		[Signature]	

**BUREAU V. S.**

**RECEIVED**

NOV 23 1956

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11718

Reg. Dist. No. 245

11698

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>			c. LENGTH OF STAY IN 1b <b>5 minutes</b> <del>hour</del>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Ieland Memorial Hospital</b>				d. STREET ADDRESS <b>4522 Madison Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Gertrude</b> Middle <b>Elizabeth</b> Last <b>Whitefield</b>				<b>4. DATE OF DEATH</b> Month <b>11-</b> Day <b>11</b> Year <b>19 56</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>4-11-29</b>		<b>9. AGE</b> (In years last birthday) <b>27</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>At Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Robert Bateman</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Ethel Cross</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service)		<b>17. INFORMANT</b> <b>Thomas Whitefield:</b> Address <b>Same address.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO (b) <b>Acute congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) <b>Cardiovascular renal disease.</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/>. and find that death resulted from: Noturol causes <input checked="" type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <i>John T. Maloney</i> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b>	
<b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>11-12-56</b>	
<b>22a. BURIAL CREMATION</b> <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>Nov. 15, 1956</b>		<b>22c. NAME OF CEMETERY OR CREMATOR</b> <b>Arlington National</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Arlington, Virginia.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. W. CHAMBERS CO., Riverdale, Maryland</b>				<b>24a. REC'D BY REGISTRAR</b> <b>Nov. 14 1956</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>James Severe</i> <i>Registrar</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further action is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Robert S. Saterman	
Sex		Male	
Date of Birth		11-11-29	
Place of Birth		Maryland	
Usual Residence		Ethel Grove	
Cause of Death		Acute coronary artery disease	
Manner of Death		Acute connective heart failure	
Place of Death		Cardiologist's renal laboratory	
Signature of Medical Examiner		John T. McManus, M.D.	
Signature of Coroner		John T. McManus, M.D.	
Signature of Physician		John T. McManus, M.D.	
Signature of Family Member		John T. McManus, M.D.	
Signature of Witness		John T. McManus, M.D.	
Signature of Other		John T. McManus, M.D.	

**RECEIVED**  
NOV 16 1956  
BUREAU V. S.

10-17-1956  
John T. McManus, M.D.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

11719

Reg. Dist. No.

11638

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's Gen. Hosp.</u>		d. STREET ADDRESS <u>30-C Crescent Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Price</u> Last <u>Winebrenner</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/8/32</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Winebrenner</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-20 1693</u>	
17. INFORMANT <u>Walter S. Winebrenner</u>		Address <u>Bladensburg, Ind</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Infarction of myocardium due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic coronary thrombosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/5</u> , 19 <u>56</u> to <u>11/5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/5</u> , 19 <u>56</u> , and that death occurred at <u>12:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Henry R. Wolfe</u> M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 8, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 13 56</u>	
24b. REGISTRAR'S SIGNATURE <u>W. F. Leach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>NOV 13 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>HOME</i>	
7. OCCUPATION <i>CLERK</i>		8. CAUSE OF DEATH <i>HEART DISEASE</i>		9. MANNER OF DEATH <i>NATURAL</i>	
10. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		11. SIGNATURE OF DEATH REGISTRAR <i>[Signature]</i>		12. SIGNATURE OF WITNESS <i>[Signature]</i>	
13. SIGNATURE OF DECEASED <i>[Signature]</i>		14. SIGNATURE OF SURVIVOR <i>[Signature]</i>		15. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>	
16. SIGNATURE OF DECEASED'S WIFE <i>[Signature]</i>		17. SIGNATURE OF DECEASED'S CHILD <i>[Signature]</i>		18. SIGNATURE OF DECEASED'S PARENT <i>[Signature]</i>	
19. SIGNATURE OF DECEASED'S SISTER <i>[Signature]</i>		20. SIGNATURE OF DECEASED'S BROTHER <i>[Signature]</i>		21. SIGNATURE OF DECEASED'S UNCLE <i>[Signature]</i>	
22. SIGNATURE OF DECEASED'S AUNT <i>[Signature]</i>		23. SIGNATURE OF DECEASED'S GRANDFATHER <i>[Signature]</i>		24. SIGNATURE OF DECEASED'S GRANDMOTHER <i>[Signature]</i>	
25. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER <i>[Signature]</i>		26. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER <i>[Signature]</i>		27. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER <i>[Signature]</i>	
28. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER <i>[Signature]</i>		29. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER <i>[Signature]</i>		30. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER <i>[Signature]</i>	

BUREAU V. 3

NOV 13 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11739 CERTIFICATE OF DEATH

11720

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Box 129, Accokeek Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>MARY</u> Last <u>WITTMAN</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 11, 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>L</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>George Beach</u>				14. MOTHER'S MARDEN NAME <u>Sarah Weatherall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Miss Jane Wittman, Accokeek, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>5190</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY CONGESTION</u> (c) <u>BILATERAL PLEURISY</u>				INTERVAL BETWEEN ONSET AND DEATH <u>14 HOURS</u> <u>ONE WEEK</u> <u>ONE WEEK</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SEVERE KYPHOSIS OF SPINE</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Accokeek</u>				20g. (County) <u>Prince Georges</u>		20h. (State) <u>MARYLAND</u>	
21. I certify that I attended the deceased from <u>NOV. 11, 1956</u> , to <u>NOV. 12, 1956</u> , that I last saw the deceased alive on <u>NOV. 12, 1956</u> , and that death occurred at <u>7:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Chen</u>				ADDRESS (Street, city or town, state) <u>Accokeek, Maryland</u>			
DATE SIGNED <u>November 12, 1956</u>							
PHYSICIAN'S NAME (Type) <u>PAUL CHEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-15-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Walkers Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Orlinton, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co., Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>Carrie Campbell</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

NOV 14 1956

CERTIFICATE OF DEATH

1956

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DIVORCE

NAME OF PREVIOUS SPOUSE

DATE OF PREVIOUS MARRIAGE

NAME OF PREVIOUS SPOUSE

DATE OF PREVIOUS MARRIAGE

NAME OF PREVIOUS SPOUSE

DATE OF PREVIOUS MARRIAGE

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